

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07501

1- For
State
Registrar

Physician/
Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

6 pm
State
Registrar

1. Decedent's Name (First, Middle, Last) Raghaviyengar Parthasarathy				2. Date of Death Month March , Day 7 , Year 2012	3. Time of Death 1:45 p M
4a. Facility Name (if not institution, give street and number) Shanti Home Assisted Living			4b. City, Town, or Location of Death Laurel		4c. County of Death Prince George
5. Social Security Number 574-14-3355		6. Sex 1 X M 2 F	7. Age (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
8. Date of Birth (Month, Day, Year) June 24, 1929			9. Birthplace (State or Foreign Country) India		
Usual Residence of Decedent					
10a. State Maryland	10b. County Prince George	10c. City, Town or Location Lanham			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number 6506 Louise Street			10f. Zip Code 20706		10g. Citizen of What Country? United States
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: Asian Indian	
15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Radio Astronomer		16b. Kind of Business Industry University of Alaska	
17. Father's Name (First, Middle, Last) Raghaviyengar			18. Mother's Name (First, Middle, Maiden Surname) Ammal		
19a. Informant's Name/Relationship (Type, Print) Sarada Parthasarathy/Spouse			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6506 Louise Street, Lanham, Maryland 20706		
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) West Arundel Crematory		20b. Place of Disposition (Name of cemetery, crematory, or other place) West Arundel Crematory		Date March 9, 2012	20c. Location - City or Town, State Odenton, Maryland
21. Signature of Funeral Service Licensee Will E. Brown Jr.		22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road, Odenton, Maryland 21113			
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death Months			
a. Stroke Due to (or as a consequence of):					
b. Hypertension Due to (or as a consequence of):		Years			
c. Diabetes Mellitus Type II Due to (or as a consequence of):		Years			
d.					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
					24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
					24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Assisted Living			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number D28998			
29b. Signature and title of certifier Pritam S. Saini, M.D.		29d. Date signed (Month, Day, Year) March 8, 2012			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pritam S. Saini, M.D., 9101 Cherry Lane, Suite 211, Laurel, Maryland 20708					
31. Date filed (Month, Day, Year) MAR 12 2012		32. Registrar's Signature James J. Park			

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07502

1 - For
State
Registrar

1. Decedent's Name (First, Middle, Last)

CATHERINE PETRY

2. Date of Death

Month MAR Day 10 Year 2012

3. Time of Death

1407 M

Physician/
Medical
Examiner

4a. Facility Name (if not institution, give street and number)

UNIVERSITY OF MARYLAND MEDICAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

Maryland

Funeral
Director

5. Social Security Number

218-24-9505

Usual Residence of Decedent

6. Sex

1 M 2 F

7. Age (in yrs. last birthday)

82

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Jan. 3, 1930

9. Birthplace (State or Foreign Country)

Maryland

To Be Completed by Funeral Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 29a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

10a. State

MD

10b. County

Carroll

10c. City, Town or Location

New Windsor

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

207 Lambert Ave.

10f. Zip Code

21776

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.
Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

waitress

16b. Kind of Business/Industry

food service

17. Father's Name (First, Middle, Last)

Stanley Burns

18. Mother's Name (First, Middle, Maiden Surname)

Helen Garber

19a. Informant's Name/Relationship (Type, Print)

W. Harold Petry - husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 457, New Windsor, MD 21776

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Winters Cemetery

Date

3/14/2012

20c. Location - City or Town, State

New Windsor, MD

21. Signature of Funeral Service Licensee

[Signature]

L. Brothman

22. Name and Address of Facility

Hartzler Funeral Home

P.O. Box 249, New Windsor, MD 21776

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. TRAUMATIC BRAIN INJURY
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. FALL
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. _____

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No
9 Unknown

23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (Specify)
9 Unknown

23d. Date of delivery

Month Day Year

[Signature]
CERTIFICATE APPROVED BY MEDICAL EXAMINER

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

coronary artery disease

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

Other:

4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 5 Pending Investigation
2 Accident 6 Could not be determined
3 Suicide
4 Homicide

28a. Date of injury (Month, Day, Year)

MAR 9 2010

28b. Time of injury

1500

28c. Injury at work?

1 Yes 2 No

28d. Describe how injury occurred

fall from standing

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

at home

28f. Location (Street and Number or Rural Route Number, City or Town, State)

207 LAMBERT ST NEW WINDSOR MD

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

only one)

only one)</p

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07503

1 - For
State
Registrar

Physician/
Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
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Physician/
Medical
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

Reber, Jeffrey Alan
Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

1 - For State Registrar		1. Decedent's Name (First, Middle, Last) Jeffrey A. Reber				2. Date of Death Month: March Day: 6 , Year: 2012		3. Time of Death 6:07 PM	
Physician/ Medical Examiner		4a. Facility Name (if not institution, give street and number) Suburban Hospital				4b. City, Town, or Location of Death Bethesda		4c. County of Death Montgomery	
Funeral Director		5. Social Security Number 178-42-8984	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 58 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) September 29, 1953	9. Birthplace (State or Foreign Country) Pennsylvania	
To Be Completed by Funeral Director		10a. State: Maryland 10b. County: Montgomery 10c. City, Town or Location: Chevy Chase				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
To Be Completed by Funeral Director		10e. Street and Number 4242 East West Highway, Apt. 810				10f. Zip Code 20815		10g. Citizen of What Country? United States	
To Be Completed by Funeral Director		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates. 1975-1978	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. White	
To Be Completed by Funeral Director		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ College (1-4 or 5+) Map Editor				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry Government	
To Be Completed by Funeral Director		17. Father's Name (First, Middle, Last) Melvin F. Reber				18. Mother's Name (First, Middle, Maiden Surname) Madelon M. Bressler			
To Be Completed by Funeral Director		19a. Informant's Name/Relationship (Type, Print) Madelon Reber / Mother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2105 West Norwegian Street, Pottsville, PA 17901			
To Be Completed by Funeral Director		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Schuylkill Memorial Park				20b. Place of Disposition (Name of cemetery, crematory or other place) Schuylkill Memorial Park		Date: March 10, 2012	20c. Location - City or Town, State Schuylkill Haven, Pennsylvania
To Be Completed by Funeral Director		21. Signature of Funeral Service Licensee Matthew Leonard				22. Name and Address of Facility Robert A. Humphrey Funeral Home / Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501			
To Be Completed by Funeral Director		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)				Approximate Interval Between Onset and Death			
To Be Completed by Funeral Director		a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):							
To Be Completed by Funeral Director		b. _____ Due to (or as a consequence of):							
To Be Completed by Funeral Director		c. _____ Due to (or as a consequence of):							
To Be Completed by Funeral Director		d. _____							
To Be Completed by Funeral Director		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
To Be Completed by Funeral Director		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
To Be Completed by Funeral Director						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Funeral Director						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
To Be Completed by Funeral Director		25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
To Be Completed by Funeral Director		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
To Be Completed by Funeral Director				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
To Be Completed by Funeral Director		29a. Certifier <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number D66896				29d. Date signed (Month, Day, Year) 3/6/12	
To Be Completed by Funeral Director		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Matthew Leonard MD, 8600 Old Georgetown Rd, Bethesda MD							
To Be Completed by Funeral Director		31. Date filed (Month, Day, Year) MAR 12 2012		32. Registrar's Signature Matthew J. Parker		33. Date signed (Month, Day, Year) 20814			

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "Natural", or if items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

State
RegistrarDHMH 17 Rev 1/2001
11595

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2012 07504
Reg. No.1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year			3. Time of Death		
<i>Pauline Rasel</i>			<i>March 7 2012</i>			<i>11:10 AM</i>		
4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death			4c. County of Death		
<i>Johns Hopkins Bayview Medical Center</i>			<i>Baltimore</i>			<i>Maryland</i>		
5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>86</i> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) <i>April 24, 1925</i>	9. Birthplace (State or Foreign Country) <i>MD</i>	
Usual Residence of Decedent			10a. State <i>MD</i> 10b. County <i>Baltimore</i> 10c. City, Town or Location <i>Dundalk</i>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <i>3119 Shortway</i>			10f. Zip-Code <i>21222</i>			10g. Citizen of What Country? <i>USA</i>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <i>1945</i>		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <i>White</i>			14. Race - American Indian, Black, White, etc. Specify: <i>White</i>	
15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Homemaker</i>			16b. Kind of Business/Industry <i>Own Home</i>		
17. Father's Name (First, Middle, Last) <i>JACK Cappelli</i>			18. Mother's Name (First, Middle, Maiden Surname) <i>Emma Schriver</i>					
19a. Informant's Name/Relationship (Type, Print) <i>Cindy Reinhold - Daughter</i>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>222 Colgate Ave, Dundalk, MD 21222</i>					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>Bayview Crematory</i>			20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Bayview Crematory</i>			Date <i>3/12/2012</i>	20c. Location - City or Town, State <i>Baltimore, MD</i>	
21. Signature of Funeral Service Licensee <i>[Signature]</i>			22. Name and Address of Facility <i>Bridley - Ashton Funeral Home, PA, 2134 Willow Springs Rd, Dundalk</i>			Approximate Interval Between Onset and Death		
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Sepsis</i>			23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Sequentially list conditions, if any, leading to immediate cause. Enter 1 Underlying Cause (Disease or injury that initiated events resulting in death) Last			23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			23f. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		23g. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			24a. Certifier (check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			24b. Describe how injury occurred		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <i>Stacey A. Schott MD</i>			27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		
28a. Date of Injury (Month, Day Year)			28b. Time of Injury M			28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred	
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State) <i>4940 Eastern Avenue, Baltimore, MD, 21224</i>		
29b. Signature and title of certifier <i>Stacey A. Schott MD</i>			29c. License number <i>RES 000</i>			29d. Date signed (Month, Day, Year) <i>March 7, 2012</i>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>STACEY A. SCHOTT MD</i>			31. Date filed (Month, Day, Year) <i>MAR 12 2012</i>			32. Registrar's Signature <i>[Signature]</i>		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07505

1 - For
State
Registrar

Physician/
Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Department of Health and Mental Hygiene
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month March Day 5 Year 2012		3. Time of Death 1:45 P M
Patricia Rouse				
4a. Facility Name (if not institution, give street and number) Vantage House		4b. City, Town, or Location of Death Columbia		4c. County of Death Howard
5. Social Security Number 224-66-4266		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days Hours Min.
Usual Residence of Decedent				
10a. State Maryland		10b. County Howard		10c. City, Town or Location Columbia
10e. Street and Number 5400 Vantage Point Road Apt 808		10f. Zip Code 21044		10g. Citizen of What Country? U.S.A.
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+		16b. Kind of Business/Industry Co-Founder of the Enterprise Foundation Non Profit
17. Father's Name (First, Middle, Last) Albert Maser Traugott		18. Mother's Name (First, Middle, Maiden Surname) Myrtle Perkins		
19a. Informant's Name/Relationship (Type, Print) John Rixey (Son)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 744 Harness Creek View Drive Annapolis, Maryland 21403		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Columbia Memorial Park		Date 3-12-2012
21. Signature on Funeral Service Licensee ► Msk Hackman MO1050		22. Name and Address of Facility Witzke Funeral Homes, Inc. 5555 Twinknolls Road Columbia, Maryland 21045		20c. Location - City or Town, State Clarksville, Maryland
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		Approximate Interval Between Onset and Death Cyanophane
<p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> <p>{</p> <p>a. Due to (or as a consequence of):</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician 2 <input type="checkbox"/> Medical Examiner 3 <input type="checkbox"/> Certifying Nurse Practitioner		To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		
29b. Signature and title of certifier ►		29c. License number D47447		29d. Date signed (Month, Day, Year) March 6, 2012
30. Name and address of person with compiled cause of death (Item 23a) (Type, Print) Andrew Lazier		31. Date filed (Month, Day, Year) MAR 12 2012		32. Registrar's Signature Leanne J. Parker

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Medical Certificate: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07506

1- For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) LUCY Robinson			2. Date of Death Month March Day 4 Year 2012		3. Time of Death 4:30 A M
	4a. Facility Name (if not institution, give street and number) The Johns Hopkins Hospital			4b. City, Town, or Location of Death Baltimore City		4c. County of Death N/A
Funeral Director	5. Social Security Number 220-03-8687	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min.	8. Date of Birth (Month, Day, Year) 06/22/1921	9. Birthplace (State or Foreign Country) Maryland
To Be Completed by Funeral Director	10a. State MD 10b. County N/A 10c. City, Town or Location Baltimore					10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number 201 N. Washington St. Apt 202			10f. Zip Code 21231		10g. Citizen of What Country? U.S.A.
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th Grade		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Arts & Crafts		16b. Kind of Business/Industry Self	
	17. Father's Name (First, Middle, Last) Albert Raison			18. Mother's Name (First, Middle, Maiden Surname) Alice Lomax		
	19a. Informant's Name/Relationship (Type, Print) Eulalia Silver (Grandchild)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 310 E. 33rd St., Baltimore, MD 21218		
Physician/ Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Dietrich N. Williams		20b. Place of Disposition (Name of cemetery, crematory or other place) King Mem. Park		Date 03/12/12	20c. Location - City or Town, State Baltimore, MD
Medical Certificate: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Joseph H. Brown Jr. Funeral Home PA			22. Name and Address of Facility 2140 N. Fulton Ave., Baltimore, MD 21217		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)			Approximate Interval Between Onset and Death		
	a. Due to (or as a consequence of): Lactic Acidosis					
	b. Due to (or as a consequence of): Chronic Lymphocytic Leukemia					
	c. Due to (or as a consequence of):					
	d. Due to (or as a consequence of):					
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
	23f. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
	29b. Signature and title of certifier Kelly W. Mitchell, M.D.			29c. License number D68872		29d. Date signed (Month, Day, Year) March 04, 2012
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kelly W. Mitchell, MD					
	31. Date filed (Month, Day, Year) MAR 12 2012			32. Registrar's Signature Barbara S. Paik		

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07507

1- For
State
RegistrarPhysician/
Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07507

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death	
Marion Smith		03 08 2012				6:20 PM	
4a. Facility Name (if not institution, give street and number) Futurecare Old Court		4b. City, Town, or Location of Death Randallstown				4c. County of Death Baltimore	
5. Social Security Number 231-60-5284 Usual Residence of Decedent		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 09-21-25	9. Birthplace (State or Foreign Country) MD	
10a. State ND		10b. County Baltimore		10c. City, Town or Location Randallstown			10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
10e. Street and Number 9109 Bengal Rd.		10f. Zip Code 21133			10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Dean of Women		16b. Kind of Business/Industry St. Paul's College			
17. Father's Name (First, Middle, Last) Matthew HASKINS		18. Mother's Name (First, Middle, Maiden Surname) Olena HASKINS					
19a. Informant's Name/Relationship (Type, Print) Robina S. Puryear/Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 797 11th Ave. Apt 64, Paterson, NJ 07514					
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro		Date 03-10-12	20c. Location - City or Town, State Baltimore, MD		
21. Signature of Funeral Service Licensee James A. Motter		22. Name and Address of Facility JAMES AMORTON & SONS 1701 LAURENS ST. BALTIMORE, MD 21217					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
a. Due to (or as a consequence of): Pneumonia b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.							
Approximate Interval Between Onset and Death							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic atrial fibrillation Diabetes Mellitus Type II							
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		23f. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of Injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier TAHOORA KAWAJA		29c. License number D 25112		29d. Date signed (Month, Day, Year) 03/09/2012			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TAHOORA KAWAJA 20 Crossroads Drive Suite 101 Owings Mills MD 21117							
31. Date filed (Month, Day, Year) MAR 12 2012		32. Registrar's Signature James A. Motter					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07508

1 - For State Registrar

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) <i>Paul Albert Smith</i>		2. Date of Death Month <i>March</i> Day <i>7</i> Year <i>2012</i>		3. Time of Death <i>1931 M</i>	
Funeral Director		4a. Facility Name (if not institution, give street and number) <i>Good Samaritan</i>		4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death <i>N/A</i>	
To Be Completed by Funeral Director		5. Social Security Number <i>214-24-4087</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <i>85 Yrs.</i>	
		8. Date of Birth (Month, Day, Year) <i>January 1, 1927</i>		9. Birthplace (State or Foreign Country) <i>Maryland</i>		10. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
		10a. State <i>Md</i>		10b. County <i>N/A</i>		10c. City, Town or Location <i>Baltimore</i>	
		10e. Street and Number <i>2621 Kirk Avenue</i>		10f. Zip Code <i>21218</i>		10g. Citizen of What Country? <i>USA</i>	
		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates. <i>8</i>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <i>Black</i>	
		15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Contractor</i>		16b. Kind of Business Industry <i>Construction</i>	
		17. Father's Name (First, Middle, Last) <i>IRVIN Smith</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>Unknown</i>		19. Informant's Name/Relationship (Type, Print) <i>Paulette Smith daughter</i>	
		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>King Memorial</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>King Memorial</i>		Date <i>March 15, 2012</i>	20c. Location - City or Town, State <i>Baltimore, Maryland</i>
		21. Signature of Funeral Service Licensee <i>Edith Wynn MO1215</i>		22. Name and Address of Facility <i>Edith Wynn Funeral Service 270 Fred Hilton Pass Baltimore Maryland</i>			
Physician/ Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>ACUTE MYOCARDIAL INFARCTION</i>				Approximate Interval Between Onset and Death	
		a. Due to (or as a consequence of): <i>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</i>					
		b. Due to (or as a consequence of): <i></i>					
		c. Due to (or as a consequence of): <i></i>					
		d. Due to (or as a consequence of): <i></i>					
Medical Certificate: To Be Completed by Physician/Medical Examiner		IF FEMALE:		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <i>9 Unknown</i>		23d. Date of delivery Month Day Year	
		23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown					
		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Medical Certificate: To Be Completed by Physician/Medical Examiner		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
		27. Manner of Death <i>1 Natural 2 Accident 3 Suicide 4 Homicide</i>		28a. Date of injury (Month, Day, Year) <i></i>		28b. Time of injury M <i>1 Yes 2 No</i>	
		28c. Injury at work? <i></i>		28d. Describe how injury occurred <i></i>		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <i></i>	
		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <i>D58933</i>		29d. Date signed (Month, Day, Year) <i>MARCH 7, 2012</i>	
		29b. Signature and title of certifier <i>Keith Joseph MD</i>		29c. License number <i>D58933</i>		29d. Date signed (Month, Day, Year) <i>MARCH 7, 2012</i>	
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>KERITH JOSEPH MD 5601 Locust RAVEN BLVD BALTIMORE, MD 21239</i>		32. Registrar's Signature <i>Susan P. Farrel</i>		31. Date filed (Month, Day, Year) <i>MAR 12 2012</i>	

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amend item 26 per doc 8925 3-12-12.vt

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07509

1- For
State
Registrar

1. Decedent's Name (First, Middle, Last)

Priscilla Gail Southworth

2. Date of Death

Month

March

Day

8

Year

2012

3. Time of Death

7:46 AM

Physician/
Medical
Examiner

4a. Facility Name (if not institution, give street and number)

832 Brunswick Road, Apt. 2B

4b. City, Town, or Location of Death

Essex

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

414-64-0134

6. Sex

M F

7. Age (in yrs. last birthday)

71

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

3/3/1941

9. Birthplace (State or Foreign Country)

Tennessee

To Be Completed by Funeral Director

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Essex

10d. Inside City Limits

Yes No

10e. Street and Number

832 Brunswick Road, Apt. 2B

10f. Zip Code

21221

10g. Citizen of What Country?

USA

11. Marital Status

Never Married Married
 Widowed Divorced

12. Was Decedent Ever in U.S. Armed Forces?

Yes No
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Yes No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) 9

College (1-4 or 5+) _____

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Waitress

16b. Kind of Business/Industry

Restaurant

17. Father's Name (First, Middle, Last)

Robert Laws

18. Mother's Name (First, Middle, Maiden Surname)

Lucy Webb

19a. Informant's Name/Relationship (Type, Print)

Cynthia Dawn Frye (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

309 Magnolia Terrace, Baltimore, MD 21221

20a. Method of Disposition

Burial Cremation Removal from State
 Donation Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bayview Crematory

Date

3/12/2012

20c. Location - City or Town, State

Baltimore

21. Signature of Funeral Service Licensee

Richard J. Frye

22. Name and Address of Facility

Bruzdzinski Funeral Home, PA

1407 Old Eastern Ave., Essex, MD 21221

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death

20 yrs

Coronary Artery Disease

a. Due to (or as a consequence of):

High Cholesterol

b. Due to (or as a consequence of):

Hypertension

c. Due to (or as a consequence of):

d. _____

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

Yes No

9 Unknown

23c. If yes, outcome of pregnancy

Live Birth Fetal death Ectopic pregnancy
 Pregnant at time of death Other (specify) _____

9 Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PVD, Atrial Fibrillation, Past Smoking, COPD

23e. Did tobacco use contribute to the cause of death?

Yes No Probably Unknown

25. Was case referred to medical examiner?

Yes No

Hospital:

Inpatient ER/Outpatient DOA

Other:

Nursing Home Residence Other (Specify)

27. Manner of Death

Natural

Accident

Suicide

Homicide

Pending Investigation

Could not be determined

28a. Date of injury (Month, Day, Year)

M

28b. Time of injury

M

28c. Injury at work?

Yes No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

00066659

29d. Date signed (Month, Day, Year)

3/8/2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thomas K. Kryszta 1576 Merritt Blvd Ste. 14 Baltimore, MD 21212

31. Date filed (Month, Day, Year)

MAR 12 2012

32. Registrar's Signature

Anna S. Patel

Division of Vital Records

P.O. Box

68760

Baltimore, Maryland

21215-0036

Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

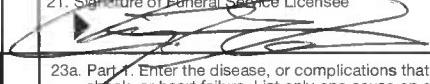
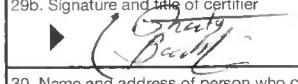
State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2012 07510
Reg. No.1 - For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Steven Seifert			2. Date of Death Month March Day 11 Year 2012		3. Time of Death 1058AM				
	4a. Facility Name (if not institution, give street and number) The Johns Hopkins Hospital			4b. City, Town, or Location of Death Baltimore City			4c. County of Death			
Funeral Director	5. Social Security Number 213-52-2651	6. Sex 1 X M 2 □ F	7. Age (In yrs. last birthday) 60 Yrs.	If Under 1 Year Months 0	If Under 24 Hrs. Hours 0	Min. 0	8. Date of Birth (Month, Day, Year) 11/22/1951	9. Birthplace (State or Foreign Country) Maryland		
To Be Completed by Funeral Director	10a. State Maryland	10b. County Baltimore	10c. City, Town or Location Middle River					10d. Inside City Limits 1 □ Yes 2 X No		
	10e. Street and Number 35 Transverse Avenue			10f. Zip Code 21220			10g. Citizen of What Country? U.S.A.			
	11. Marital Status 1 □ Never Married 2 X Married	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 X No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 X No Specify:			14. Race - American Indian, Black, White, etc. White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Drywall Technician			16b. Kind of Business/Industry Construction			
	17. Father's Name (First, Middle, Last) Norman Lee Seifert, Sr.			18. Mother's Name (First, Middle, Maiden Surname) Mary Elizabeth Louise Knight						
	19a. Informant's Name/Relationship (Type, Print) Kathy Seifert (Wife)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 35 Transverse Avenue, Baltimore, Maryland 21220						
	20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Carmel Cemetery			Date 03/16/2012	20c. Location - City or Town, State Baltimore, Maryland		
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221						
Physician Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sepsis								Approximate Interval Between Onset and Death	
	a. Due to (or as a consequence of): Sepsis									
	b. Due to (or as a consequence of): Spontaneous Bacterial Peritonitis									
	c. Due to (or as a consequence of):									
	d. Due to (or as a consequence of):									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		23c. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown			23d. Date of delivery Month Day Year				
Medical Certificate: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 X No 3 □ Probably 4 □ Unknown	
									24a. Was an autopsy performed? 1 □ Yes 2 X No	
									24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No	
	25. Was case referred to medical examiner? 1 □ Yes 2 X No		26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)							
	27. Manner of Death 1 X Natural 5 □ Pending Investigation 2 □ Accident 6 □ Could not be determined 3 □ Suicide 4 □ Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? 1 □ Yes 2 □ No	28d. Describe how injury occurred			
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 □ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number R ES - 000			29d. Date signed (Month, Day, Year) March 11, 2012				
	29b. Signature and title of certifier 									
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MOHAMED ELSHAZLY		31. Date filed (Month, Day, Year) MAR 12 2012			32. Registrar's Signature 				

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07511

1- For
State
Registrar

Physician/
Medical
Examiner

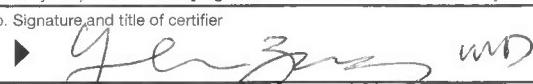
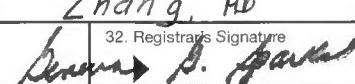
Baltimore, Maryland 21215-0036

Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/
Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Medical Certificate: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death	
Vivian L. Slade		Month March		Day 4, 2012 Year 7:35 P M	
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death	
Medstar Montgomery Medical Center		Olney		Montgomery	
5. Social Security Number 219-46-8220		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F Yrs. 66		7. Age (In yrs. last birthday) If Under 1 Year Months Days Hours Min. 8. Date of Birth (Month, Day, Year) January 6, 1946	
Usual Residence of Decedent Maryland		10a. State Montgomery		10b. County Rockville	
10c. City, Town or Location Rockville		10f. Zip Code 20853		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 4707 Holly Ridge Road		10g. Citizen of What Country? United States			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)		16b. Kind of Business/Industry Commercial Cleaning Business Office Manager	
17. Father's Name (First, Middle, Last) Zane Walker		18. Mother's Name (First, Middle, Maiden Surname) Wilma Brandt			
19a. Informant's Name/Relationship (Type, Print) Lynn C. Slade / Husband		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4707 Holly Ridge Road, Rockville, Maryland 20853			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Carmel Cemetery		Date March 9, 2012	20c. Location - City or Town, State Sunshine, Maryland
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 M01305			
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Due to (or as a consequence of): <i>Pulmonary Fibrosis</i>		Approximate Interval Between Onset and Death Unknown	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. Due to (or as a consequence of):			
		b. Due to (or as a consequence of):			
		c. Due to (or as a consequence of):			
		d. Due to (or as a consequence of):			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier 		29c. License number DG1624		29d. Date signed (Month, Day, Year) March 5, 2012	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Yuanjie L. Zhang, MD		31. Date filed (Month, Day, Year) MAR 12 2012		32. Registrar's Signature 	

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07512

1 - For
State
Registrar

Physician/
Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department. If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Month Day Year		3. Time of Death 4:15 PM
James A. Schoettler, Sr.		March 6, 2012		
4a. Facility Name (if not institution, give street and number) 9112 Brierly Road		4b. City, Town, or Location of Death Chevy Chase		4c. County of Death Montgomery
5. Social Security Number 571-26-5429		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 80 Yrs.	If Under 1 Year Months Days Hours Min. 8. Date of Birth (Month, Day, Year) June 13, 1931
Usual Residence of Decedent Maryland		10a. State Montgomery		9. Birthplace (State or Foreign Country) California
10b. County Montgomery		10c. City, Town, or Location Chevy Chase		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
10e. Street and Number 9112 Brierly Road		10f. Zip Code 20815		10g. Citizen of What Country? United States
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates. 1958-1968		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Physician		16b. Kind of Business/Industry Psychiatry
17. Father's Name (First, Middle, Last) Harold Joseph Schoettler		18. Mother's Name (First, Middle, Maiden Surname) Loretta Shea		
19a. Informant's Name/Relationship (Type, Print) Ell Louise Schoettler/Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9112 Brierly Road, Chevy Chase, Maryland 20815		
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Montgomery Crematorium		Date March 9, 2012
21. Signature of Funeral Service Licensee ► Bryan A. Pumphrey		22. Name and Address of Facility Robert A. Pumphrey Funeral Home, Bethesda-Chevy Chase, Inc 7557 Wisconsin Avenue, Bethesda, Maryland 20814		20c. Location - City or Town, State Bethesda, Maryland
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Bladder Cancer		Approximate Interval Between Onset and Death 3 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		Cerebro Vascular Accident		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
Atrial Fibrillation				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
Multiple Sclerosis, Peripheral Neuropathy				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number D0014107		29d. Date signed (Month, Day, Year) March 7, 2012
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bryan Arling, M.D. 2440 M Street, NW, Washington, D.C. 20037				
31. Date filed (Month, Day, Year) MAR 12 2012		32. Registrar's Signature Bryan A. Arling		

Please Type or Print In Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician/ Medical Examiner		Registrar							Reg. No.	
		1. Decedent's Name (First, Middle, Last) James Jay Semmel				2. Date of Death Month Day Year March 7, 2012		3. Time of Death 2318 hrs		
Funeral Director		4a. Facility Name (if not institution, give street and number) 13483 Brighton Dam Road			4b. City, Town, or Location of Death Clarksville			4c. County of Death Howard		
		5. Social Security Number 105-32-5886		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 70 Yrs.	If Under 1 Year Months 4	If Under 24 Hrs. Days 29	8. Date of Birth (MM/DD/YYYY) 4/29/1941	9. Birthplace (State or Foreign Country) New York	
To Be Completed by Funeral Director		10e. State MD		10b. County Howard	10c. City, Town or Location Clarksville				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
		10e. Street end Number 13483 Brighton Dam Road				10f. Zip Code 21029		10g. Citizen of What Country? USA		
Physician /Medical Examiner		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: White		14. Race - American Indian, Black, White, etc.		
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th		College (1-4 or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Owner & Operator		16b. Kind of Business/Industry Restaurant		
To Be Completed by Physician/Medical Examiner		17. Father's Name (First, Middle, Last) Frank H. Semmel				18. Mother's Name (First, Middle, Maiden Surname) Ruby H. Benson				
		19a. Informant's Name/Relationship (Type, Print) Joanne C. Semmel/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13483 Brighton Dam Road, Clarksville, MD 21029				
To Be Completed by Physician/Medical Examiner		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify: Janice D. Cook		20b. Place of Disposition (Name of cemetery, crematory or other place) St. Louis Cemetery		Date 3/12/2012	20c. Location - City or Town, State Clarksville, MD			
		21. Signature of Funeral Service Licensee Janice D. Cook		22. Name and Address of Facility M01103 313 Talbott Avenue, Laurel, MD 20707						
To Be Completed by Physician/Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.							Approximate Interval Between Onset and Death	
		<input type="checkbox"/> UNPENDED		<input checked="" type="checkbox"/> AMENDED 4a, per phy, g925 3-12-12 sm						
To Be Completed by Physician/Medical Examiner		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
To Be Completed by Physician/Medical Examiner		25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)		
To Be Completed by Physician/Medical Examiner		29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier D. Vincenti		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) March 8, 2012		
State Registrar		30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223		31. Date filed (Month, Day, Year) MAR 12 2012		32. Registrar's Signature [Signature]				

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed

To the Hospital or Attending

Division of Vital Records, P.O. Box 68760, **Alaska Department of Health and Social Services**

Division of Vital Records, P.O. Box 68760, **Alaska Department of Health and Social Services**

□

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OGME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM 720a-C, 22 PER 11, 0925, 3/21/2012, 15

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07514

1 - For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Gregory Howard Smith					2. Date of Death Month Day Year March 3, 2012	3. Time of Death Hour Minute AM/PM 6:05 p M		
	4a. Facility Name (if not institution, give street and number) Maryland General Hospital					4b. City, Town, or Location of Death Baltimore		4c. County of Death City	
Funeral Director	5. Social Security Number 213-80-7333	6. Sex 1 X M 2 F	7. Age (in yrs. last birthday) 56 Yrs.	If Under 1 Year Months Days Hours Min. 	If Under 24 Hrs. 	8. Date of Birth (Month, Day, Year) Feb 10, 1956	9. Birthplace (State or Foreign Country) Florida		
To Be Completed by Funeral Director	10a. State MD		10b. County Baltimore		10c. City, Town or Location Baltimore			10d. Inside City Limits 1 X Yes 2 No	
	10e. Street and Number 1027 Cathedral St. Apt 11A			10f. Zip Code 21201			10g. Citizen of What Country? USA		
	11. Marital Status 1 □ Never Married 2 X Married 3 □ Widowed 4 □ Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 X No Specify:		14. Race - American Indian, Black, White, etc. Specify: white		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 0		16b. Kind of Business/Industry laborer CSX Railroad				
	17. Father's Name (First, Middle, Last) unk				18. Mother's Name (First, Middle, Maiden Surname) unk				
	19a. Informant's Name/Relationship (Type, Print) Nicole Smith - wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1027 Cathedral St; Apt 11A; Baltimore, MD 21201						
	20a. Method of Disposition 1 □ Burial 2 X Cremation 3 □ Removal from State 4 □ Donation 5 X Other (Specify) in state		20b. Place of Disposition (Name of cemetery, crematory or other place) Atlantic Crem.		Date 3-18-2012	20c. Location - City or Town, State Glen Burnie, MD			
Physician/ Medical Examiner	21. Signature of Funeral Service Licensee Ronald J. Wale, Director		22. Name and address of Facility, State, and County Board Simplicity Cremation and Funeral Services 707 W. Baltimore St., Baltimore, MD 21201 Thomas Allen P.A. 7090 Ridge Rd., Hanover, MD						
Medical Certificate: To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death	
	<p>a. Hepatitis C Due to (or as a consequence of): Peripheral Vascular Disease</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. </p>								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		23c. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown					23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 □ Probably 4 X Unknown	
								24a. Was an autopsy performed? 1 □ Yes 2 X No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
	25. Was case referred to medical examiner? 1 X Yes 2 □ No		Hospital: 1 □ Inpatient 2 X ER/Outpatient 3 □ DCA		26. Place of Death (Check only one) Other: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)				
	27. Manner of Death 1 X Natural 5 □ Pending Investigation 2 □ Accident 6 □ Could not be determined 3 □ Suicide 4 □ Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 □ Yes 2 □ No	28d. Describe how injury occurred			
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 □ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number D0070336					29d. Date signed (Month, Day, Year) 3/3/2012	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Steven P. Tropetti, M.D. % Maryland General Hospital								
	31. Date filed (Month, Day, Year) MAR 12 2012		32. Registrar's Signature Leanne S. Parker						

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07515

1 - For
State
Registrar

Physician/
Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Jean D. Sites

2. Date of Death

Month March Day 2 Year 2012

3. Time of Death

10:30 P M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

4c. County of Death
Frederick

5. Social Security Number

216-74-2073

6. Sex

M F

7. Age (In yrs. last birthday)

79

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)

June 26, 1932

9. Birthplace (State or Foreign
Country)

Maryland

To Be Completed by Funeral Director

Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

Usual Residence of Decedent

10a. State

MD

10b. County

Frederick

10c. City, Town or Location

Mt. Airy

10d. Inside City Limits

Yes No

10e. Street and Number

7000 Kimmel Rd.

10f. Zip Code

21771

10g. Citizen of What Country?

USA

11. Marital Status

Never Married Married
 Widowed Divorced

12. Was Decedent Ever in U.S. Armed Forces?

Yes No
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Yes No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Seconday (0-12) 0

College (1-4 or 5+) 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

disabled

16b. Kind of Business Industry

none

17. Father's Name (First, Middle, Last)

unk

18. Mother's Name (First, Middle, Maiden Surname)

Emma Werneth

19a. Informant's Name/Relationship (Type, Print)

William Sites - brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7261 Gough St; Baltimore, MD 21224

20a. Method of Disposition

Burial Cremation Removal from State
 Donation Other (Specify) in state

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licens

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201

Approximate Interval Between Onset and Death weeks

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Cerebrovascular Accident

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. _____

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
 Yes No
 Unknown

23c. If yes, outcome of pregnancy
 Live Birth Fetal death Ectopic pregnancy
 Pregnant at time of death Other (specify) _____
 Unknown

23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

Yes No Probably Unknown

24a. Was an autopsy performed?
 Yes No

24b. Were autopsy findings available prior to completion of cause of death?
 Yes No

25. Was case referred to medical examiner?

Yes No

26. Place of Death (Check only one)

Hospital: Inpatient ER/Outpatient DOA

Other:

Nursing Home Residence Other (Specify) Hospice

27. Manner of Death

Natural
 Accident
 Suicide
 Homicide

Pending Investigation
 Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work?

Yes No

M

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Eric Bush MD

D68104

3/6/2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Eric Bush MD, 516 Trail Ave, Frederick, MD 21702

31. Date filed (Month, Day, Year)

MAR 12 2012

32. Registrar's Signature

James J. Pace

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For State Registrar Amend Item 2 per ar., g926, 04/03/2012 ab State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2012 07516

Physician/
Medical
ExaminerFuneral
Director

Baltimore, Maryland 21215-0036
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) Linda Joy Silvia							2. Date of Death Month February Day 20 , Year 2012	3. Time of Death 10:45 P M
4a. Facility Name (if not institution, give street and number) Gilchrist Hospice				4b. City, Town, or Location of Death Towson			4c. County of Death Baltimore	
5. Social Security Number 215-42-8985		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 68 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month Day, Year) Dec 25, 1943	9. Birthplace (State or Foreign Country) Virginia	
10a. State MD		10b. County Baltimore		10c. City, Town or Location Essex				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number 1000 Franklin Ave; apt 302				10f. Zip Code 21221			10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) laborer			16b. Kind of Business/Industry factory	
17. Father's Name (First, Middle, Last) Hanstel Gale Feathers					18. Mother's Name (First, Middle, Maiden Surname) Margent Vilio Sharrett			
19a. Informant's Name/Relationship (Type, Print) Kenneth W. Doughtery - son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2464 Twinbrook Rd; Hickory, NC 28602				
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place)			Date	20c. Location - City or Town, State
21. Signature of Funeral Service Licensee Ronald S. Wade, Director				22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201				

Division of Vital Records, P.O. Box 68760
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

23a. Part I. Underline the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPSIS		Approximate Interval Between Onset and Death days			
b. Due to (or as a consequence of): Mesenteric Ischemia		months			
c. Due to (or as a consequence of): Vascular disease		years			
d.					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown			
23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) HOSPICE			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number D58303		29d. Date signed (Month, Day, Year) February 21 2012	
29b. Signature and title of certifier Gerardine		29c. License number D58303		29d. Date signed (Month, Day, Year) February 21 2012	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALLEN J CHARLES MD 6701 N Charles ST TOWSON MD					
31. Date filed (Month, Day, Year) MAR 12 2012		32. Registrar's Signature Laura J. Spack			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2012 07517

1. For State
RegistrarPhysician/
Medical Examiner

Reg. No.

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death 1950 hrs
--	------------------------------------	------------------------------

Christian Wiley Smith

March 9, 2012

1950 hrs

Funeral
Director

4a. Facility Name (if not institution, give street and number) Laurel Regional Hospital	4b. City, Town, or Location of Death Laurel	4c. County of Death Prince George's
--	--	--

5. Social Security Number 212-17-2174	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 28 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (MM/DD/YYYY) April 9, 1983	9. Birthplace (State or Foreign Country) Maryland
--	--	---	---	--	--

Usual Residence of Decedent

10a. State MD	10b. County Anne Arundel	10c. City, Town or Location Laurel	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
------------------	-----------------------------	---------------------------------------	--

10e. Street and Number 3506 Ridgemoor Drive	10f. Zip Code 20724	10g. Citizen of What Country? USA
--	------------------------	--------------------------------------

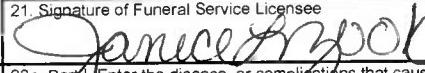
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No specify:	14. Race - American Indian, Black, White, etc. Specify: White
--	--	--	--

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 2	16b. Kind of Business/Industry Electrician
--	---	---

17. Father's Name (First, Middle, Last) Thomas Edward Smith	18. Mother's Name (First, Middle, Maiden Surname) Anne Reeder
--	--

19a. Informant's Name/Relationship (Type, Print) Thomas Edward Smith/Father	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3506 Ridgemoor Drive, Laurel, MD 20724
--	---

20a. Method of Disposition 1 <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State	20b. Place of Disposition (Name of cemetery, crematory or other place) West Arundel Crem.	Date 3/12/2012	20c. Location - City or Town, State Odenton, MD
---	--	-------------------	--

21. Signature of Funeral Service Licensee 	22. Name and Address of Facility Donaldson Funeral Home, P.A. 313 Talbott Avenue, Laurel, MD 20707
--	--

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	a. Methadone Intoxication Due to (or as a consequence of):	Approximate Interval Between Onset and Death
--	--	--

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):
	c. Due to (or as a consequence of):
	d. Due to (or as a consequence of):

<input checked="" type="checkbox"/> UNPENDED	<input type="checkbox"/> AMENDED 23a, 27, 28a-f, per me, g925 3-19-12 sm
--	--

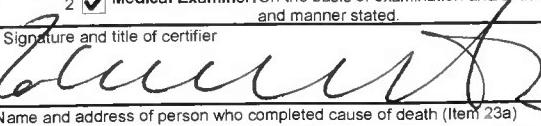
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
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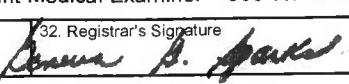
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other:
---	--

27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day, Year) fd 3-9-12	28b. Time of Injury fd 1845 hrs	28c. Injury at Work? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred unknown
--	---	------------------------------------	---	--

28e. Place of Injury - At home, farm, street, factory, office building, etc. Residence	28f. Location (Street and Number or Rural Route Number, City or Town, State) 3506 Ridgemore Dr. Laurel, MD.
---	--

29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29b. Signature and title of certifier 	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) March 10, 2012
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30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

31. Date filed (Month, Day, Year) MAR 12 2012	32. Registrar's Signature 
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Division of Vital Records, P.O. Box 68760, Baltimore, MD 21215-0036
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitThe law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician/
Medical
Examiner**

1 - For
State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

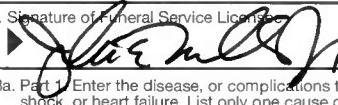
Certificate of Death

2012 07518
Reg. No.

**Funeral
Director**

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		Michaelena L. Stange				2. Date of Death Month March Day 7 Year 2012	3. Time of Death 9:15 p M			
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death Baltimore				4c. County of Death N/A				
5. Social Security Number 216-32-8058		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 76 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	Min.	8. Date of Birth (Month, Day, Year) January 24, 1936	9. Birthplace (State or Foreign Country) Maryland		
Usual Residence of Decedent Md.		10b. County N/A		10c. City, Town or Location Baltimore				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 6716 Roberts Ave.				10f. Zip Code 21222			10g. Citizen of What Country? USA			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 years			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Housewife				16b. Kind of Business/Industry Own Home			
17. Father's Name (First, Middle, Last) Stewart Kirtz					18. Mother's Name (First, Middle, Maiden Surname) Anna Shultz					
19a. Informant's Name/Relationship (Type, Print) Karen Miller Daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 38 Honeysuckle Drive, Port Deposit, Md. 21904							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Crestlawn Cemetery			Date March 12, 2012	20c. Location - City or Town, State Marriottsville, Md.			
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
Immediate Cause (Final disease or condition resulting in death) Coronary Arterial Disease										
Approximate Interval Between Onset and Death										
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
<p>a. _____ Due to (or as a consequence of): Hyperlipidemia</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____						23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. COPD										
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown										
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number D7300		29d. Date signed (Month, Day, Year) 3/9/12						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lonnie Fuller 3700 Fleet St. Baltimore MD 21224										
31. Date filed (Month, Day, Year) MAR 12 2012		32. Registrar's Signature 								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

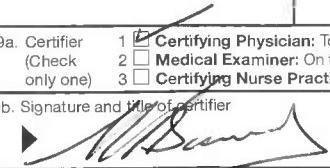
AMEND ITEM#1perPHYS, G925, 3/14/2012, WS
State of Maryland / Department of Health and Mental Hygiene

2012 07519

Reg. No.

1 - For
State
Registrar

Certificate of Death

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Creston Martien Smith Jr.						2. Date of Death Month March Day 7 Year 2012	3. Time of Death 20:30 PM					
	4a. Facility Name (If not institution, give street and number) Howard County General Hospital			4b. City, Town, or Location of Death Columbia			4c. County of Death Howard						
Funeral Director	5. Social Security Number 214-16-8117	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) Dec. 27, 1921	9. Birthplace (State or Foreign Country) Maryland						
To Be Completed by Funeral Director	Usual Residence of Decedent MD Baltimore		10a. State 10b. County 10c. City, Town or Location Catonsville					10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
	10e. Street and Number 310 Glenrae Drive			10f. Zip Code 21228			10g. Citizen of What Country? USA						
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. White Specify:						
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) Accountant		16b. Kind of Business/Industry Automobile								
	17. Father's Name (First, Middle, Last) Creston Martien Smith, Sr.			18. Mother's Name (First, Middle, Maiden Surname) Bertha Mae Griffith									
	19a. Informant's Name/Relationship (Type, Print) Creston M. Smith, III Son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 31 Pendleton Court North; Frederick, MD 21703									
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest VA Cem			Date 3/21/2012	20c. Location - City or Town, State Owings Mills, MD					
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc 1630 Edmondson Avenue; Catonsville, MD 21228									
Physician/ Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pneumonia								Approximate Interval Between Onset and Death Eighteen days				
Medical Certificate: To Be Completed by Physician/Medical Examiner	23b. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last {												
	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown								23d. Date of delivery Month Day Year				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide								28a. Date of injury (Month, Day, Year) March		28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								29b. Signature and title of certifier  MD				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shadab Bavaei								29c. License number D64874		29d. Date signed (Month, Day, Year) March 8, 2012		
	31. Date filed (Month, Day, Year) MAR 12 2012				32. Registrar's Signature 								

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

Medical Certificate: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1981

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07520

1- For State Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Margaret Scerba</i>							2. Date of Death Month <input checked="" type="checkbox"/> March Day <input checked="" type="checkbox"/> 7 Year <input checked="" type="checkbox"/> 2012	3. Time of Death <input checked="" type="checkbox"/> 10:45A M
	4a. Facility Name (if not institution, give street and number) 1205 McCurley Avenue			4b. City, Town, or Location of Death Catonsville			4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 217-14-6489		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 98 Yrs.	If Under 1 Year Months <input type="checkbox"/> Days <input type="checkbox"/>	If Under 24 Hrs. Hours <input type="checkbox"/> Min. <input type="checkbox"/>	8. Date of Birth (Month, Day, Year) May 11, 1913	9. Birthplace (State or Foreign Country) Italy	
	Usual Residence of Decedent MD Baltimore		10c. City, Town or Location Catonsville					10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number 1205 McCurley Avenue				10f. Zip Code 21228			10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Office Clerk		16b. Kind of Business/Industry Engravers				
	17. Father's Name (First, Middle, Last) Alfred Lanciotti				18. Mother's Name (First, Middle, Maiden Surname) Catherine Dente				
	19a. Informant's Name/Relationship (Type, Print) Catherine Cottrell Daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1205 McCurley Avenue; Catonsville, MD 21228					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>Mary M0234</i>			20b. Place of Disposition (Name of cemetery, crematory or other place) New Cathedral Cemetery		Date <input type="checkbox"/> 3/10/2012	20c. Location - City or Town, State Baltimore, MD		
	21. Signature of Funeral Service Licensee <i>Mary M0234</i>			22. Name and Address of Facility Sterling Ashton Schwab Ritzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228					
Physician/ Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Atherosclerotic Cardiovascular Disease</i>								Approximate Interval Between Onset and Death
	<p>a. Due to (or as a consequence of): <i>Atherosclerotic Cardiovascular Disease</i></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <i>Unknown</i>				23d. Date of delivery Month <input type="checkbox"/> Day <input type="checkbox"/> Year		
Medical Certificate: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA		Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <i>Residence</i>		26. Place of Death (Check only one)		
Medical Certificate: To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year) <i>2835 Smith St</i>		28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred <i>At home, farm, street, factory, office building, etc. (Specify)</i>		
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <i>2835 Smith St</i>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <i>Baltimore MD 21205</i>				
	29b. Signature and title of certifier <i>N S Rajapakse MD</i>		29c. License number <i>DO057465</i>		29d. Date signed (Month, Day, Year) <i>3/7/12</i>				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>N S Rajapakse MD</i>		31. Date filed (Month, Day, Year) MAR 12 2012		32. Registrar's Signature <i>Barbara S. Gaikwad</i>				

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 25 per me, g925, 03/12/2012dhb

State of Maryland / Department of Health and Mental Hygiene

Amend Items 23a,28a-f per me, g925, 03/08/2012dhb

Certificate of Death

Reg. No.

2012 07521

1- For State Registrar

Physician/
Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit: Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

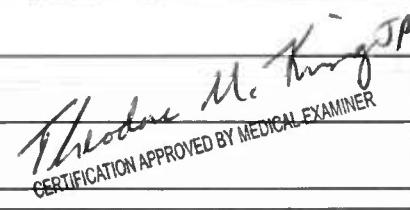
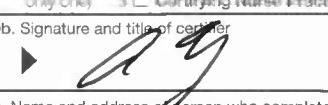
Physician/
Medical
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760
Baltimore, MD 21205-68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. Decedent's Name (First, Middle, Last) Gertrude L. Shook												2. Date of Death Month 02 Day 17 Year 2012	3. Time of Death 2:04 P M
4a. Facility Name (if not institution, give street and number) Anne Arundel Medical Center						4b. City, Town, or Location of Death Annapolis				4c. County of Death Anne Arundel			
5. Social Security Number 242-36-9082		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 02/03/1929	9. Birthplace (State or Foreign Country) NC						
10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Millersville				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number 1237 Dicus Mill Road				10f. Zip Code 21108				10g. Citizen of What Country? U.S.A.					
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)				16b. Kind of Business/Industry Bookkeeper					
17. Father's Name (First, Middle, Last) Blaine Potter						18. Mother's Name (First, Middle, Maiden Surname) Viola Church							
19a. Informant's Name/Relationship (Type, Print) Mr. Ronnie Shook / son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 430 Ski Lane, Millersville, Maryland 21108									
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) M01357				20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven Mem Park				Date 2/22/2012	20c. Location - City or Town, State Glen Burnie, Maryland				
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility 1 2nd Ave, SW Glen Burnie, MD Singleton Funeral & Cremation Services, P.A.									
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): subdural hematoma Approximate Interval Between Onset and Death Days													
b. Due to (or as a consequence of): Fall Approximate Interval Between Onset and Death Days													
c. Due to (or as a consequence of):  Theodore M. King, Jr., M.D. CERTIFICATION APPROVED BY MEDICAL EXAMINER													
d. Due to (or as a consequence of):													
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____								23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Myocardial infarction Dementia													
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown													
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No													
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No													
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA				Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year) 02/16/2012		28b. Time of injury 2215 pM		28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred Fell out of Bed					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Hospital													
28f. Location (Street and Number or Rural Route Number, City or Town, State) Annapolis, MD Anne Arundel Medical Center													
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. Signature and title of certifier 		29c. License number PS-55187				29d. Date signed (Month, Day, Year) 2/17/12							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anne Arundel Medical Center													
31. Date filed (Month, Day, Year) MAR 08 2012		32. Registrar's Signature 											

1- For State
RegistrarPhysician/
Medical Examiner

Certificate of Death

Reg. No.

2012 07522

Funeral
Director

To Be Completed by Funeral Director

Baltimore, MD 21215-0036
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
 Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any
 injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerDivision of Vital Records, P.O. Box 68760,
 To the Hospital or Attending Physician: The law requires that the death certificate be executed
 within 24 hours after death.To the Funeral Director: After this certificate has been signed by the attending physician and
 completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Dey Year		3. Time of Death 0947 hrs
Kenneth Earl Tutton		February 28, 2012		
4a. Facility Name (if not institution, give street and number) 4904 41st Place		4b. City, Town, or Location of Death Hyattsville		4c. County of Death Prince George's
5. Social Security Number <input type="text"/> unk		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 63 Yrs.	If Under 1 Year Months Days Hours Min.
8. Date of Birth (MM/DD/YYYY) Sept 20, 1948		9. Birthplace (State or Country) Washington, D.C.		10. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10a. State MD		10b. County Prince Georges		10c. City, Town or Location Hyattsville
10e. Street and Number 4904 41st Place		10f. Zip Code 20781		10g. Citizen of What Country? USA
11. Marital Status <input type="text"/> unk 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="text"/> unk 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: Specify: white
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <input type="text"/> unk Machine Operator		16b. Kind of Business/Industry <input type="text"/> unk Postal Service
17. Father's Name (First, Middle, Last) <input type="text"/> unk Wilfred Tutton		18. Mother's Name (First, Middle, Maiden Surname) <input type="text"/> unk Iva June Center		
19a. Informant's Name/Relationship (Type, Print) OCME Dale Tutton-brother		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) General Delivery; Hyattsville, Maryland 20781 900 W. Baltimore St., Baltimore, MD 21223		
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other Specify: in state		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date
21. Signature of Funeral Service Licensed Ronald S. Wade, Director		22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201		20c. Location - City or Town, State
23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Gunshot Wound of Head Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____				
<input type="checkbox"/> UNPENDED		<input type="checkbox"/> AMENDED		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene		
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury FOUND: Feb 28, 2012	28b. Time of Injury 0947 hrs	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
		28d. Describe how injury occurred Subject shot self		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Single Family Home
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28f. Location (Street and Number or Rural Route Number, City or Town, State) 4904 41st Place, Hyattsville, MD		
29b. Signature and title of certifier Ling Li, MD Assistant Medical Examiner		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) February 29, 2012
30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223				
31. Date filed (Month, Day, Year) MAR 12 2012		32. Registrar's Signature James A. Wade		

ORIGINAL

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
 amend #1, per phy, g925 3-12-12 sm
 amend 4c, per fh, g925 3-12-12 sm

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07523

1- For State Registrar

**Physician/
Medical
Examiner**

**Funeral
Director**

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. Decedent's Name (First, Middle, Last)			Ethel Vanger				2. Date of Death		3. Time of Death		
<i>Vanger, Ethel</i>							Month March Day 07 Year 2012		01:18 PM		
4a. Facility Name (if not institution, give street and number)			Randallstown				4b. City, Town, or Location of Death		4c. County of Death		
<i>Northwest Hospital</i>							Baltimore USA		Baltimore USA		
5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)				If Under 1 Year		If Under 24 Hrs.		
219-32-6920		<input type="checkbox"/> M <input checked="" type="checkbox"/> F	96 Yrs.				Months	Days	Hours	Min.	
Usual Residence of Decedent											
10a. State	10b. County		10c. City, Town or Location		BALTIMORE				10d. Inside City Limits		
MD	BALTIMORE		BALTIMORE						<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number			10f. Zip Code				10g. Citizen of What Country?				
4204 OLD MILFORD MILL ROAD			21208				USA				
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			14. Race - American Indian, Black, White, etc.			
<input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			Specify: WHITE			
15. Decedent's Education (Specify only highest grade completed)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business/Industry					
Elementary/Secondary (0-12) 12			College (1-4 or 5+) OFFICE MANAGER			ORTHODONTIST					
17. Father's Name (First, Middle, Last)			18. Mother's Name (First, Middle, Maiden Surname)								
SAMUEL SIMON			FANNIE			BURKHART					
19a. Informant's Name/Relationship (Type, Print)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)								
F. LEANNA CHAMISH/GRANDDAUGHTER			6127 PARKWAY DRIVE, BALTIMORE, MD 21212								
20a. Method of Disposition			20b. Place of Disposition (Name of cemetery, crematory or other place)			Date			20c. Location - City or Town, State		
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			ADATH YESHURUN CEM.			03/09/2012			BALTIMORE, MD		
21. Signature of Funeral Service Licensee			22. Name and Address of Facility			SOL LEVINSON & BROS., INC.					
<i>Susan E.</i>			8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208								

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death	
{ a. <i>Aspiration Pneumonia</i> Due to (or as a consequence of): b. <i>Chronic Heart Failure</i> Due to (or as a consequence of): c. <i>Urinary Tract Infection</i> Due to (or as a consequence of): d. <i>Deep Venous Thrombosis</i>		unknown unknown 8 days unknown	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
--	--	---	--	---	--

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	

25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
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27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
								28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
								28f. Location (Street and Number or Rural Route Number, City or Town, State)	

29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Aneta Giamatikova, MD</i>		29c. License number <i>872810</i>		29d. Date signed (Month, Day, Year) <i>March 07, 2012</i>	
--	--	---	--	--------------------------------------	--	--	--

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)				31. Date filed (Month, Day, Year) <i>MAR 12 2012</i>				32. Registrar's Signature <i>Leanne S. Parker</i>	
<i>Aneta Giamatikova, MD 5401 Old Court Road, Randallstown, MD 21133</i>									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07524

1- For State
RegistrarPhysician/
Medical ExaminerFuneral
Director

To Be Completed by Funeral Director

Baltimore, MD 21245-0036

Important: If item 27 is marked other than "natural", or items 23a or 28-f show any injury or other traumatic event, file Medical Examiner must be notified at once.

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

		1. Decedent's Name (First, Middle, Last)						2. Date of Death Month Day Year			3. Time of Death 1527 hrs	
		Charles J. Williams, Jr.						March 2, 2012				
		4a. Facility Name (if not institution, give street and number)			4b. City, Town, or Location of Death			4c. County of Death				
		6805 Walker Mill Road			Capitol Heights			Prince George's				
		5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24Hrs.	8. Date of Birth (MM/DD/YYYY)	9. Birthplace (State or Foreign)				
		577-15-7751	1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	31 Yrs.	Months	Days	Hours	Min.	06-25-1980 Washington, DC			
		Usual Residence of Decedent						10d. Inside City Limits				
		10a. State	10b. County	10c. City, Town or Location						1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
		DC		Washington								
		10e. Street and Number			10f. Zip Code			10g. Citizen of What Country?				
		1616 K Street, NE #102			20002			U.S.A.				
		11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			14. Race - American Indian, Black, White, etc.					
		1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced	1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify:			Specify: Black					
		15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business/Industry					
		Elementary/Secondary (0-12) 11th		College (1-4 or 5+) Home Improvement			Private					
		17. Father's Name (First, Middle, Last)						18. Mother's Name (First, Middle, Maiden Surname)				
		Charles J. Williams, Sr.						Ellen L. Marshall				
		19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)								
		Ellen L. Marshall - Mother		1616 K Street, NE #102 Washington, DC 20002								
		20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)			Date	20c. Location - City or Town, State				
		1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:		Heritage Memorial Pk. Ft. Lincoln Cemetery			03-24-2012	Waldorf, MD Brentwood, Maryland				
		21. Signature of Funeral Service Licensee		22. Name and Address of Facility			Ronald Taylor II Funeral Home 10583 Middleport Lane, White Plains, Md. 20695					
		<i>Ronald Taylor</i>										
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
		Approximate Interval Between Onset and Death										
		Immediate Cause (Final disease or condition resulting in death) a. Metastatic Hepatic Carcinoma with complications Due to (or as a consequence of):										
		b. _____ Due to (or as a consequence of):										
		c. _____ Due to (or as a consequence of):										
		d. _____										
		<input checked="" type="checkbox"/> UNPENDED		<input type="checkbox"/> AMENDED 23a, 27, per me, g926 4-2-12 sm								
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year					
		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown										
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown										
		25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene			24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred				
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)					
		29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
		29b. Signature and title of certifier <i>Ana Rubio</i>		29c. License number O.C.M.E.			29d. Date signed (Month, Day, Year) March 3, 2012					
		30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223										
		31. Date filed (Month, Day, Year) MAR 12 2012		32. Registrar's Signature <i>Leanne J. Parker</i>								

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for us as the burial - transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Steven Thomas Watkins

12-01415

Unk Unk

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07525

Physician/
Medical Examiner1. For State
Registrar

1. Decedent's Name (First, Middle, Last)

Steven Thomas Watkins

2. Date of Death

Month Day

Year

3. Time of Death

1135 hrs

Funeral
Director

To Be Completed by Funeral Director

4a. Facility Name (if not institution, give street and number)

1800 block of S. Monroe Street

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

5. Social Security Number unk 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 55 Yrs. If Under 1 Year Months Days Hours Min. 8. Date of Birth (MM/DD/YYYY) Aug 30, 1956 9. Birthplace (State or Foreign Country) unk

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, MD 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Physician/
Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

10a. State MD 10b. County unk 10c. City, Town or Location unk 10d. Inside City Limits unk 1 Yes 2 No

10e. Street and Number unk 10f. Zip Code unk 10g. Citizen of What Country? USA

11. Marital Status unk 12. Was Decedent Ever in U.S. Armed Forces? unk 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.

1 Yes 2 No specify: white

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk 16b. Kind of Business/Industry unk

unk

unk

17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk

19a. Informant's Name/Relationship (Type, Print) OCME 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 900 W. Baltimore St; Baltimore, MD 21201

20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: in state 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State

21. Signature of Funeral Service Licensee Ronald S. Wade, Director 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):

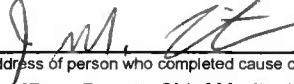
b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

 UNPENDED AMENDED 23a,27,per me,g925 3-14-12 smIF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown 23d. Date of delivery Month Day YearPart II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other: Scene27. Manner of Death 1 Natural 5 Pending Investigation 2 Accident 3 Suicide 4 Homicide 6 Could not be determined 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Yes 2 No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.29b. Signature and title of certifier  29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) February 18, 2012

30. Name and address of person who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

31. Date filed (Month, Day, Year) MAR 12 2012 32. Registrar's Signature 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07526

1- For
State
RegistrarPhysician/
Medical
Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death	
<i>Gertude A. Waters</i>		3-7-2012		7:50P M	
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death	
<i>Season's Hospice</i>		<i>Randallstown</i>		<i>Baltimore</i>	
5. Social Security Number		6. Sex	7. Age (in yrs. last birthday)	If Under 1 Year Months Days Hours Min.	
<i>219-03-5805</i>		<input type="checkbox"/> M <input checked="" type="checkbox"/> F	<i>96</i> Yrs.		
8. Date of Birth (Month, Day, Year)		9. Birthplace (State or Foreign Country)			
<i>8-8-1915</i>		<i>MJ</i>			
10a. State		10b. County	10c. City, Town or Location		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<i>MD</i>		<i>Baltimore</i>	<i>Windsor Mills</i>		
10e. Street and Number		10f. Zip Code		10g. Citizen of What Country?	
<i>7809 Liberty Road</i>		<i>21244</i>		<i>USA</i>	
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
<i>1 Never Married 2 Married 3 Widowed 4 Divorced</i>					
15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry	
<i>Elementary/Secondary (0-12) 10</i>		<i>Custodial Laborer</i>		<i>U.S. Government</i>	
17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)			
<i>Frank Smith</i>		<i>Sarah Emery</i>			
19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
<i>Wade Young / Son</i>		<i>4524 Mary Knoll Rd, Kesville, MD 21208</i>			
20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date	20c. Location - City or Town, State
<i>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Vaughn C. Greene</i>		<i>Woodlawn</i>		<i>3-7-2012</i>	<i>Baltimore, MD</i>
21. Signature of Funeral Service Licensee		22. Name and Address of Facility			
<i>Vaughn C. Greene</i>		<i>Vaughn C. Greene Funeral Services 8728 Liberty Rd, Randallstown, MD 21133</i>			
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death) <i>Congestive heart failure</i>					
Approximate Interval Between Onset and Death <i>Month</i>					
23b. Part 2. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
a. Due to (or as a consequence of):					
b. Due to (or as a consequence of):					
c. Due to (or as a consequence of):					
d. Due to (or as a consequence of):					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (specify) <i>Inpatient hospital</i>		23f. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
					28d. Describe how injury occurred
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29b. Signature and title of certifier <i>Karen W. Metzger</i>		29c. License number <i>00043375</i>		29d. Date signed (Month, Day, Year) <i>03/08/2012</i>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Karen W. Metzger 6934 AVIATION BLDG SUITE N-R BURLEIGH, MD 21061</i>					
31. Date filed (Month, Day, Year) <i>MAR 12 2012</i>		32. Registrar's Signature <i>Karen P. Metzger</i>			

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07527

1 - For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Lindsey Agee</i>							2. Date of Death Month Feb. Day 25 Year 2012	3. Time of Death 9:30 P M	
	4a. Facility Name (if not institution, give street and number) <i>1444 Cambr. Age Beltway</i>			4b. City, Town, or Location of Death <i>Cambridge</i>			4c. County of Death <i>Dorchester</i>			
Funeral Director	5. Social Security Number <i>426-84-2371</i>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>70 Yrs.</i>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <i>Aug. 1, 1941</i>	9. Birthplace (State or Foreign Country) <i>Mississippi</i>			
Usual Residence of Decedent 10a. State <i>MD</i> 10b. County <i>Dorchester</i> 10c. City, Town or Location <i>Cambridge</i> 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
To Be Completed by Funeral Director	10e. Street and Number <i>1444 Cambridge Beltway</i>			10f. Zip Code <i>21613</i>			10g. Citizen of What Country? <i>USA</i>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>4</i> College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Teacher</i>			16b. Kind of Business Industry <i>Board of Education</i>			
	17. Father's Name (First, Middle, Last) <i>John Agee</i>			18. Mother's Name (First, Middle, Maiden Surname) <i>Mahalia Combest</i>						
	19a. Informant's Name/Relationship (Type, Print) <i>Sandra Sanders</i>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>99 Shady Oak Rd. Laurel, Mississippi 39443</i>						
Physician/ Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Nora Davis Cemetery</i>			Date <i>3/8/12</i>	20c. Location - City or Town, State <i>Laurel, Mississippi</i>		
Medical Certificate: To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Congestive Heart Failure</i> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>Dilated Cardiomyopathy</i>									
	Approximate Interval Between Onset and Death									
	23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown									
	23d. Date of delivery Month Day Year									
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
Medical Certificate: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide									
	28a. Date of Injury (Month, Day, Year) <i>28b. Time of injury M</i> 28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred									
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)									
	29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	29b. Signature and title of certifier <i>Eugene Newmyer DO</i> 29c. License number <i>H51793</i> 29d. Date signed (Month, Day, Year) <i>2/28/12</i>									
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Eugene Newmyer DO 321 Rochester Ave, Suite 1 Cambridge MD 21613</i>									
State Registrar	31. Date filed (Month, Day, Year) <i>FEB 28 2012</i> 32. Registrar's Signature <i>[Signature]</i>									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

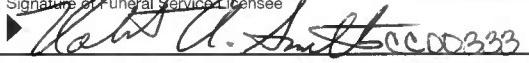
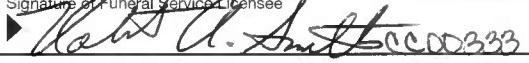
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg No. 2012 07528

3. Time of Death

1 - For
State
Registrar

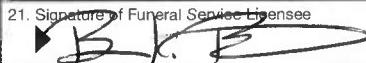
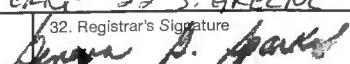
Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Sterling Hayden Armstead							2. Date of Death Month February Day 23 , Year 2012		3. Time of Death 1543 hrs				
	4a. Facility Name (if not institution, give street and number) Shady Grove Adventist Hospital							4b. City, Town, or Location of Death Rockville		4c. County of Death Montgomery				
Funeral Director	5. Social Security Number 226-58-5972		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 69 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) 1942 August 28,	9. Birthplace (State or Foreign Country) Virginia						
	Usual Residence of Decedent Virginia		10c. City, Town or Location Charlottesville		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No									
To Be Completed by Funeral Director	10e. Street and Number 1087 Dry Bridge Road				10f. Zip Code 22903		10g. Citizen of What Country? United States							
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates. Elementary/Secondary (0-12) 11th grade		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Supervisory Custodian		14. Race - American Indian, Black, White, etc. Specify: Black						
	15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) 12th grade				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) River House Company			16b. Kind of Business/Industry River House Company						
	17. Father's Name (First, Middle, Last) Robert Lee Armstead				18. Mother's Name (First, Middle, Maiden Surname) Mary Isabell Wilson									
	19a. Informant's Name/Relationship (Type, Print) (Sister) Edmonia Armstead McNeal				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12 Brassie Court; Montgomery Village, Maryland 20886									
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) 			20b. Place of Disposition (Name of cemetery, crematory or other place) Mount Calvary Baptist Church Cemetery; Ivy, Virginia		Date March 3, 2012	20c. Location - City or Town, State Albemarle County, Virginia							
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility R. N. Horton Company Morticians, Inc.; 600 Kennedy Street, N.W.; Washington, D.C. 20011									
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Respiratory Failure Due to (or as a consequence of): pulmonary fibrosis Due to (or as a consequence of): thrombembolic disease Due to (or as a consequence of): Diabetes								Approximate Interval Between Onset and Death 1 hour years years					
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year						
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year) 28b. Time of injury M 28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
									28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number D64235						29d. Date signed (Month, Day, Year) February 23, 2012					
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joel Buzy MD 9901 Medical Cir Dr Rockville, MD 20850								31. Date filled (Month, Day, Year) FEB 27 2012		32. Registrar's Signature 			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1 - For State Amend Item 25 per me, g925,0370872012dhb Certificate of Death

Reg. No. 2012 07529

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) HAROLD ABBOTT					2. Date of Death Month FEB Day 8 Year 2012	3. Time of Death 1322 P			
	4a. Facility Name (if not institution, give street and number) UNIVERSITY OF MARYLAND MEDICAL CENTER					4b. City, Town, or Location of Death BALTIMORE		4c. County of Death		
Funeral Director	5. Social Security Number 218-24-2670		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months 	If Under 24 Hrs. Hours 	8. Date of Birth (Month, Day, Year) Dec. 23, 1928	9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent MD Dorchester		10c. City, Town or Location Cambridge					10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number 5314 Backwoods Drive				10f. Zip Code 21613			10g. Citizen of What Country? USA		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates WWII			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. white
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) maintenance			16b. Kind of Business/Industry wire cloth mfg.			
17. Father's Name (First, Middle, Last) William Parks Abbott					18. Mother's Name (First, Middle, Maiden Surname) Lorraine Robbins					
19a. Informant's Name/Relationship (Type, Print) Beverly Abbott wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5314 Backwoods Drive, Cambridge, MD 21613						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Cem			Date 2/16/12	20c. Location - City or Town, State Hurlock, MD		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 21613						
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) GALL STONE PANCREATITIS										
Approximate Interval Between Onset and Death										
b. Due to (or as a consequence of): 										
c. Due to (or as a consequence of): 										
d. Due to (or as a consequence of): 										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown						23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ABDOMINAL PHLEGMON, ACUTE KIDNEY INJURY, CORONARY ARTERY DISEASE									23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
									24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA			Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		26. Place of Death (Check only one)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred				
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input checked="" type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								29d. Date signed (Month, Day, Year) 2 - 8 - 12		
29b. Signature and title of certifier 		29c. License number R133788								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUSAN OTREMBA CRP 22 S. GREENE STREET BALTIMORE MARYLAND 21201										
31. Date filed (Month, Day, Year) MAR 08 2012		32. Registrar's Signature 								

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

Within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07530

1 - For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Mary Buchanan</i>					2. Date of Death Month Day Year <i>Feb 19 2012</i>	3. Time of Death <i>1050 A.M.</i>
	4a. Facility Name (if not institution, give street and number) <i>Anne Arundel Medical Center</i>			4b. City, Town, or Location of Death <i>Annapolis</i>		4c. County of Death <i>Anne Arundel</i>	
Funeral Director	5. Social Security Number <i>547-54-3544</i>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>78 Yrs.</i>	If Under 1 Year Months Days Hours Min. 	8. Date of Birth (Month, Day, Year) <i>3/2/1933</i>	9. Birthplace (State or Foreign Country) <i>California</i>	
To Be Completed by Funeral Director	10a. State <i>Maryland</i>			10b. County <i>Anne Arundel</i>	10c. City, Town or Location <i>Annapolis</i>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number <i>1114 River Crescent Drive</i>			10f. Zip Code <i>21401</i>		10g. Citizen of What Country? <i>USA</i>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates. 		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: 		14. Race - American Indian, Black, White, etc. Specify: <i>White</i>
	15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>USNA Tour Guide</i>			16b. Kind of Business/Industry <i>USNA Public Relations</i>
	17. Father's Name (First, Middle, Last) <i>Charles Allen Buchanan</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Kathleen Thompson</i>		
	19a. Informant's Name/Relationship (Type, Print) <i>Kathleen Buchanan Lee - Sister</i>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>4802 Jamestown Rd, Bethesda, MD 20816</i>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>Baltimore Crematory</i>			20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Baltimore Crematory</i>		Date <i>2/23/2012</i>	20c. Location - City or Town, State <i>Baltimore, MD</i>
	21. Signature of Funeral Service Licensee <i>Melvin D. Hobart</i>			22. Name and Address of Facility John M. Taylor Funeral Home <i>147 Duke of Gloucester St, Annapolis, MD 21401</i>			
Physician/ Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Acute Renal Failure</i> Approximate Interval Between Onset and Death <i>36 hrs.</i>						
	23b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>Sepsis</i> Approximate Interval Between Onset and Death <i>36 hrs.</i>						
	23c. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown						
	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown						
	23d. Date of delivery Month Day Year						
Medical Certificate: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Cdifficile, HTN, RA, Gerd, Hypothyroid, RCS Lambert-Eaton, Cellulitis, Addisons</i>						
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No						
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DCA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide						
	28a. Date of injury (Month, Day, Year) 28b. Time of injury M 28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No						
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						
	28d. Describe how injury occurred						
	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
	29b. Signature and title of certifier <i>Hospitalist</i>						
	29c. License number <i>H0052024</i>						
	29d. Date signed (Month, Day, Year) <i>2/19/2012</i>						
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>James Walker, DO, 2001 Medical Parkway, Annapolis MD 21401</i>						
State Registrar	31. Date filed (Month, Day, Year) <i>FEB 21 2012</i>						
	32. Registrar's Signature <i>James D. Parks</i>						

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Certificate of Death

Reg. No.

2012 07531

1 - For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Ronald Thomas Brady							2. Date of Death Month 02 Day 22 Year 2012	3. Time of Death 214 M
	4a. Facility Name (if not institution, give street and number) Meritus Medical Center Emertis Medical Center				4b. City, Town, or Location of Death Hagerstown			4c. County of Death Washington	
Funeral Director	5. Social Security Number 220-28-2931	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	Min.	8. Date of Birth (Month, Day, Year) APR 23 1934	9. Birthplace (State or Foreign Country) Brunswick, MD	
To Be Completed by Funeral Director	10a. State MD	10b. County Washington	10c. City, Town or Location Hagerstown					10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 17004 Burwood Court				10f. Zip Code 21740			10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Communications			16b. Kind of Business/Industry Dept. of Energy		
	17. Father's Name (First, Middle, Last) Walter Brady				18. Mother's Name (First, Middle, Maiden Surname) Catherine Bell Mountain				
	19a. Informant's Name/Relationship (Type, Print) Joan Brady, Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17004 Burwood Court, Hagerstown, MD 21740				
Physician/ Medical Examiner	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Hagerstown Crematory			Date 2/25/12	20c. Location - City or Town, State Hagerstown, MD	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility John T. Williams Funeral Home 100 Petersville Road, Brunswick, MD 21716				
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death acute myocardial infarction years CAD (Coronary Artery Disease) years HTN (Hypertension) years hyperlipidemia years	
	a. Due to (or as a consequence of):		b. Due to (or as a consequence of):		c. Due to (or as a consequence of):		d. Due to (or as a consequence of):		
	IF FEMALE:		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			26. Place of Death (Check only one)	
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	28d. Describe how injury occurred			
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
	29b. Signature and title of certifier 		29c. License number 170063593			29d. Date signed (Month, Day, Year) 02/23/2012			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Matthew H. G. Brown, M.D. 3 Bryant Dr. Williamsport MD 21795								
	31. Date filed (Month, Day, Year) FEB 24 2012		32. Registrar's Signature 						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07532

1 - For
State
Registrar

Physician/
Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036
Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial transit slip.

State
Registrar

1. Decedent's Name (First, Middle, Last) <i>Anna Alice Belcher</i>			2. Date of Death Month <u>February</u> Day <u>22</u> Year <u>2012</u>	3. Time of Death 1:20 PM
4a. Facility Name (if not institution, give street and number) <i>Sanctuary at Holy Cross</i>			4b. City, Town, or Location of Death <i>Burtonsville</i>	
5. Social Security Number <i>216-40-5696</i>		8. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>91</i> Yrs.	If Under 1 Year Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min.
10a. State <i>Maryland</i>		10b. County <i>Howard</i>	10c. City, Town or Location <i>Columbia</i>	8. Date of Birth Month <u>Mar</u> Day <u>5</u> Year <u>1920</u>
10e. Street and Number <i>10952 Trotting Ridge Way</i>			10f. Zip Code <i>21044</i>	10g. Citizen of What Country? <i>United States</i>
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: <i>White</i>
15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) <i>1-4</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary	16b. Kind of Business Industry <i>Insurance</i>	
17. Father's Name (First, Middle, Last) <i>Richard Franklin Farley</i>			18. Mother's Name (First, Middle, Maiden Surname) <i>Ida Ilcy Tiney</i>	
19a. Informant's Name/Relationship (Type, Print) <i>Arthur L. Belcher -son</i>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>10952 Trotting Ridge Way Columbia, Maryland 21044</i>	
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Metropolitan Crematory</i>	Date <i>2/23/2012</i>
21. Signature of Funeral Service Licensee <i>Donald V. Borgwardt</i>			20c. Location - City or Town, State <i>Alexandria, Virginia</i>	
22a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Atherosclerotic Cardiovascular Disease</i>			Approximate Interval Between Onset and Death	
Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
a. Due to (or as a consequence of): <i>Atrial fibrillation</i>				
b. Due to (or as a consequence of): <i>Chronic Obstructive Pulmonary Disease</i>				
c. Due to (or as a consequence of): <i></i>				
d. <i></i>				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <i></i>		
23d. Date of delivery Month <input type="checkbox"/> Day <input type="checkbox"/> Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Atrial fibrillation</i> <i>Chronic Obstructive Pulmonary Disease</i>				
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Injury at work? 4 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Yes <input type="checkbox"/> No		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. Signature and title of certifier <i>Dorothy Saemys</i>		29c. License number <i>D0053387</i>		29d. Date signed (Month, Day, Year) <i>February 23 2012</i>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Dorothy Saemys 2835 Smith Ave Ste 203 Beltsville Md 20709</i>				
31. Date filed (Month, Day, Year) <i>FEB 24 2012</i>		32. Registrar's Signature <i>Laura A. Parker</i>		

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07533

1- For
State
Registrar

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death A.M./P.M.	
Philip Marie Barnard		02 25 2012				11:45 A.M.	
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death				4c. County of Death	
15859 Maryland Highway		Swanton				Garrett	
5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) March 13 1928	9. Birthplace (State or Foreign Country) Maryland
6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 83 Yrs.					
10a. State MD		10b. County Garrett	10c. City, Town or Location Swanton				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number 15859 Maryland Highway				10f. Zip Code 21561		10g. Citizen of What Country? United States	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No (If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unknown		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Homemaker		16b. Kind of Business/Industry Housework			
17. Father's Name (First, Middle, Last) Robert Bray				18. Mother's Name (First, Middle, Maiden Surname) Rebecca Paugh			
19a. Informant's Name/Relationship (Type, Print) Ronald Barnard/ son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15859 Maryland Highway, Swanton, Maryland 21561			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cumberland Crematory		Date 02/28/2012	20c. Location - City or Town, State Cumberland Maryland		
21. Signature of Funeral Service Licensee F. Wayne Boal		22. Name and Address of Facility Boal Funeral Home 111 Church St, Westernport, Maryland 21562					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Mycloid Monocytic Leukemia 7 months							
Approximate Interval Between Onset and Death							
a. Due to (or as a consequence of):							
b. Due to (or as a consequence of):							
c. Due to (or as a consequence of):							
d. Due to (or as a consequence of):							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier Paul Daniel Miller, DO		29c. License number H26154		29d. Date signed (Month, Day, Year) 2127/2012			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul Daniel Miller, DO 69 Wolf Acres Dr Oakland MD							
31. Date filed (Month, Day, Year) FEB 28 2012		32. Registrar's Signature Anna B. Jones		Z-550			

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND #25, PER ME G932 10/3/12 TRT

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07534

1 - For
State
Registrar

Physician/
Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ATWOOD, SINCLAIR, BARWICK

2. Date of Death

Month

02

Day

18

Year

12

3. Time of Death

1:42 PM

Funeral
Director

4a. Facility Name (if not institution, give street and number)

UNIVERSITY OF MARYLAND MEDICAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

5. Social Security Number

579-42-9076

Usual Residence of Decedent

6. Sex

M

F

7. Age (In yrs. last birthday)

Yrs.

77

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

04/12/1934

9. Birthplace (State or Foreign Country)

MARYLAND

To Be Completed by Funeral Director

10a. State

MARYLAND

10b. County

KENT

10c. City, Town or Location

CHESTERTOWN

10d. Inside City Limits

Yes No

10e. Street and Number

536 CANNON STREET

10f. Zip Code

21620

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

Never Married Married

Widowed Divorced

12. Was Decedent Ever in U.S. Armed Forces?

Yes No

If Yes, Give Year or Dates.

1960

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Yes No

Specify:

14. Race - American Indian, Black, White, etc.

Specify:

WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

OCEANOGRAPHER

16b. Kind of Business/Industry

FEDERAL GOVERNMENT

17. Father's Name (First, Middle, Last)

ARTHUR RICHARDSON BARWICK

18. Mother's Name (First, Middle, Maiden Surname)

LEAH CECILIA CATLIN

19a. Informant's Name/Relationship (Type, Print)

VIRGINIA B. DILDINE / SISTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

407 NORTH ROUTE 7 FALLS VILLAGE, CT 06031

20a. Method of Disposition

Burial Cremation Removal from State
 Donation Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ST. PAUL'S CEMETERY

Date

20c. Location - City or Town, State

02/26/2012 CHESTERTOWN, MARYLAND

21. Signature of Funeral Service Licensee

► *Karen Nater*

22. Name and Address of Facility

FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A.
130 SPEER ROAD CHESTERTOWN, MARYLAND 21620

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death

CARDIORESPIRATORY FAILURE

5 DAYS

a.

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

CERTIFICATION APPROVED BY MEDICAL EXAMINER

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
 Yes No
 Unknown

23c. If yes, outcome of pregnancy

Live Birth Fetal death Ectopic pregnancy
 Pregnant at time of death Other (Specify)
 Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

Yes No Probably Unknown

24a. Was an autopsy performed?

Yes No

24b. Were autopsy findings available prior to completion of cause of death?

Yes No

25. Was case referred to medical examiner?

Yes No

26. Place of Death (Check only one)

Hospital:

Inpatient ER/Outpatient DOA

Other:

Nursing Home Residence Other (Specify)

27. Manner of Death

Natural Pending Investigation
 Accident Could not be determined
 Suicide Determined
 Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

Yes No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

► *Karen Nater, MD*

29c. License number

#101582

29d. Date signed (Month, Day, Year)

2/18/2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KAREN NATER-PINTERO 22 SOUTH GREENE STREET, BALTIMORE, MD 21201

31. Date filed (Month, Day, Year)

FEB 22 2012

32. Registrar's Signature

Karen Nater

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07535

1- For
State
RegistrarPhysician/
Medical
ExaminerFuneral
Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

STC

Medical Certificate: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month 2 Day 22 Year 12 113 M		3. Time of Death 113 M
Elsye McGlaughlin Culver Bounds				
4a. Facility Name (if not institution, give street and number) <i>Peninsula Regional Medical Center</i>		4b. City, Town, or Location of Death <i>SA 0136414</i>		4c. County of Death <i>Hanover</i>
5. Social Security Number 214-10-7416 Usual Residence of Decedent		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) 100 Yrs.	8. Date of Birth (Month, Day, Year) 11-4-1911
9. Birthplace (State or Foreign Country) Maryland	If Under 1 Year Months Days Hours Min.		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10a. State MD		10b. County Wicomico		10c. City, Town or Location Salisbury
10e. Street and Number 1110 Healthway Drive, #215		10f. Zip Code 21804		10g. Citizen of What Country? USA
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)		16b. Kind of Business/Industry Secretary Life Insurance
17. Father's Name (First, Middle, Last) Harold Stanford Culver		18. Mother's Name (First, Middle, Maiden Surname) Edna McGlaughlin		
19a. Informant's Name/Relationship (Type, Print) Carolyn E. Parsons - Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6068 Delmar Road, Delmar, Delaware 19940		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Siloam Cemetery		Date 20c. Location - City or Town, State 2-27-2012 Siloam, Maryland
21. Signature of Funeral Service Licensee <i>Melissa Keay Blahey</i>		22. Name and Address of Facility Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Immediate Cause (Final disease or condition resulting in death) <i>Congestive Heart Failure Exacerbation</i> Approximate Interval Between Onset and Death a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work? M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28d. Describe how injury occurred	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <i>P71277</i>		
29b. Signature and title of certifier <i>Z. K. Muncy, M.D.</i>		29d. Date signed (Month, Day, Year) <i>2-23-12</i>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Z. K. Muncy, M.D., 106 MILFORD ST, STE 504B, SALISBURY, MD 21804</i>				
31. Date filed (Month, Day, Year) <i>FEB 23 2012</i>		32. Registrar's Signature <i>Laura J. Parker</i>		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 24a per med cert G925 3/14/12 dk

State of Maryland / Department of Health and Mental Hygiene

2012 07536

1 - For
State
Registrar

Certificate of Death

Reg. No.

Physician/
Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Stephanie Jacqueline Brown

2. Date of Death

Month Day Year
February 19 2012

3. Time of Death

1415 M

Funeral
Director

4a. Facility Name (if not institution, give street and number)

Dorchester General Hospital

4b. City, Town, or Location of Death

Cambridge

4c. County of Death

Dorchester

5. Social Security Number

214-52-1039

6. Sex

M

F

7. Age (In yrs. last birthday)

63

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)
Feb. 4 1949

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Dorchester

10c. City, Town or Location

Cambridge

10d. Inside City Limits

Yes No

10e. Street and Number

8 Patamoke Way

10f. Zip Code

21613

10g. Citizen of What Country?

USA

11. Marital Status

Never Married Married
 Widowed Divorced

12. Was Decedent Ever in U.S. Armed Forces?

Yes No
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Yes No
Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Seconday (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Assessment Clerk

16b. Kind of Business Industry

State Gov.

17. Father's Name (First, Middle, Last)

Leon Samuel Brown Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Ella Mae Savage

19a. Informant's Name/Relationship (Type, Print)

E. Paulette Brown

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1005 Harrison Dr. Laurel, Maryland 20707

20a. Method of Disposition

Burial Cremation Removal from State
 Donation Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bethel Cemetery

Date

2/25/12

20c. Location - City or Town, State

Cambridge, MD.

21. Signature of Funeral Service Licensee

Janelle C. Henry

22. Name and Address of Facility

Henry Funeral Home, P.A.
510 Washington St, Cambridge, MD, 21613

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line.

Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death

9 months

Metastatic pancreatic carcinoma

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

{

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

Yes No

Unknown

23c. If yes, outcome of pregnancy

Live Birth Fetal death Ectopic pregnancy
 Pregnant at time of death Other (Specify)
 Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

Yes No Probably Unknown

1 Yes No

Hospital:

1 Inpatient ER/Outpatient DOA

Other:

4 Nursing Home Residence Other (Specify)

24a. Was an autopsy performed?

Yes No

24b. Were autopsy findings available prior to completion of cause of death?

Yes No

25. Was case referred to medical examiner?

Yes No

26. Place of Death (Check only one)

1 Natural

2 Accident

3 Suicide

4 Homicide

5 Pending Investigation

6 Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 Yes No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

William Hair

29c. License number

D43238

29d. Date signed (Month, Day, Year)

February 19, 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William Hair 100 Bramble St. Cambridge, MD 21613

31. Date filed (Month, Day, Year)

FEB 24 2012

32. Registrar's Signature

John B. Parker

STEPHANIE BROWN

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit

to

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012

07537

**1 - For
State
Registrar**

**Physician/
Medical
Examiner**

**Funeral
Director**

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68700

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

		1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year		3. Time of Death Hour Min.														
		WILLIAM FRANK BODDICKER			FEBRUARY 23 2012		5:45 P M														
Physician/ Medical Examiner		4a. Facility Name (If not institution, give street and number) FREDERICK MEMORIAL HOSPITAL			4b. City, Town, or Location of Death FREDERICK		4c. County of Death FREDERICK														
Funeral Director		5. Social Security Number 725-10-2006	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Jan. 1, 1930	9. Birthplace (State or Foreign Country) Iowa														
To Be Completed by Funeral Director		Usual Residence of Decedent 10a. State MD 10b. County Washington			10c. City, Town or Location Knoxville			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No													
		10e. Street and Number 1120 William Way			10f. Zip Code 21758		10g. Citizen of What Country? USA														
Physician/ Medical Examiner		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates. 1948-49		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White													
		15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Agent			16b. Kind of Business Industry Insurance													
		17. Father's Name (First, Middle, Last) Frank Joseph Boddicker			18. Mother's Name (First, Middle, Maiden Surname) Erma Stallman																
		19a. Informant's Name/Relationship (Type, Print) Jane M. Boddicker - Wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1120 William Way - Knoxville, MD 21758																
		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) St. Marys Cemetery		Date 2/27/12	20c. Location - City or Town, State Petersville, MD														
		21. Signature of Funeral Service Licensee Robert L. Seaver		22. Name and Address of Facility Eackles-Spencer & Norton Funeral Home - Harpers Ferry, WV 25425																	
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last																			
		<table border="1"> <tr> <td>a.</td> <td>Due to (or as a consequence of): SEPSIS</td> <td>Approximate Interval Between Onset and Death</td> </tr> <tr> <td>b.</td> <td>Due to (or as a consequence of): PLEURAL EFFUSION</td> <td></td> </tr> <tr> <td>c.</td> <td>Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d.</td> <td>Due to (or as a consequence of):</td> <td></td> </tr> </table>								a.	Due to (or as a consequence of): SEPSIS	Approximate Interval Between Onset and Death	b.	Due to (or as a consequence of): PLEURAL EFFUSION		c.	Due to (or as a consequence of):		d.	Due to (or as a consequence of):	
a.	Due to (or as a consequence of): SEPSIS	Approximate Interval Between Onset and Death																			
b.	Due to (or as a consequence of): PLEURAL EFFUSION																				
c.	Due to (or as a consequence of):																				
d.	Due to (or as a consequence of):																				
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year														
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																			
		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown																			
		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																			
		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)															
		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred													
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)															
		29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29c. License number MD 71068															
		29b. Signature and title of certifier R. Sathyabama Naidu				29d. Date signed (Month, Day, Year) 2/25/2012															
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. Sathyabama Naidu 400 West 7th St, Frederick MD 21701																			
		31. Date filed (Month, Year) FEB 28 2012		32. Registrar's Signature Anne J. East																	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07538

1 For
State
Registrar

Physician/
Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last)							2. Date of Death			3. Time of Death	
Virginia Frances Bolling							Month Day Year February 21, 2012 10:30 P M				
4a. Facility Name (If not institution, give street and number)				4b. City, Town, or Location of Death			4c. County of Death				
Doctors Community Hospital				Lanham			Prince George's				
5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months Days Hours Min.			8. Date of Birth (Month, Day, Year)			9. Birthplace (State or Foreign Country)	
577-26-9772		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	88 Yrs.				01/03/1924			Manassas, Va.	

Usual Residence of Decedent
10a. State
Md.
10b. County
P.G.
10c. City, Town or Location
Fairmount Heights
10e. Street and Number
1001 59th Avenue
10f. Zip Code
20743
10g. Citizen of What Country?
U.S.A.

11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. African American Specify:
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Environmental Service Worker		16b. Kind of Business/Industry P.G. County Public Schools

17. Father's Name (First, Middle, Last) Charles Randall		18. Mother's Name (First, Middle, Maiden Surname) Sadie Smith		
19a. Informant's Name/Relationship (Type, Print) Linda M. Coates/Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3315 27th Avenue, Temple Hills, Maryland 20748		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) Cedar Hill Cem.		20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cem.	Date 03/03/12	20c. Location - City or Town, State Suitland, Maryland

21. Signature of Funeral Service Licensee Darryl H. Elliott CC0316	22. Name and Address of Facility Henry S. Washington & Sons Co., Inc. 4925 Burroughs Ave., N.E., Washington, D.C. 20019
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23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) OVARIAN CANCER	Approximate Interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last { CORONARY ARTERY DISEASE	
a. Due to (or as a consequence of): coronary artery disease	
b. Due to (or as a consequence of):	
c. Due to (or as a consequence of):	
d. _____	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No

25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA	26. Place of Death (Check only one) Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)
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27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide	28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)		

29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	29c. License number DOOS59981	29d. Date signed (Month, Day, Year) 2/2/12
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29b. Signature and title of certifier Mukemil Abdella, MD	29c. License number DOOS59981	29d. Date signed (Month, Day, Year) 2/2/12
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mukemil Abdella, MD, 12200 Annapolis Rd., Suite 229, Glen Dale, MD 20709		

31. Date filed (Month, Day, Year) FEB 27 2012	32. Registrar's Signature J. Parker
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Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

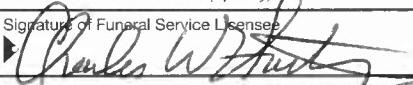
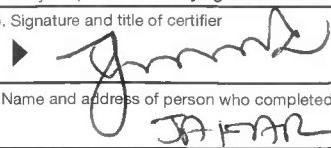
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07539

1 - For
State
Registrar

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) EUGENE W. BAILEY					2. Date of Death Month 2 Day 18 Year 2012		3. Time of Death 0104 M	
Funeral Director		4a. Facility Name (if not institution, give street and number) Peninsula Regional Medical Center			4b. City, Town, or Location of Death SALISBURY			4c. County of Death HANCOCK		
To Be Completed by Funeral Director		5. Social Security Number 231-18-5063		6. Sex 1 M	7. Age (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) FEB. 29, 1924	9. Birthplace (State or Foreign Country) WEST VIRGINIA	
		10a. State DELAWARE		10b. County SUSSEX		10c. City, Town or Location SELBYVILLE			10d. Inside City Limits 1 Yes 2 No	
		10e. Street and Number 37363 HARMONY DRIVE			10f. Zip Code 19975			10g. Citizen of What Country? USA		
		11. Marital Status 1 Never Married 2 Married		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:			14. Race - American Indian, Black, White, etc. WHITE	
		3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		If Yes, Give Year or Dates. 1943-46						
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10			16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) ENGINEER			16b. Kind of Business/Industry CONSTRUCTION		
		17. Father's Name (First, Middle, Last) OSCAR BAILEY					18. Mother's Name (First, Middle, Maiden Surname) VERLIE MILAM			
		19a. Informant's Name/Relationship (Type, Print) CELIA BAILEY/WIFE			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 37363 HARMONY DRIVE, SELBYVILLE, DE. 19975					
		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State			20b. Place of Disposition (Name of cemetery, crematory or other place) CREMATORIAL OF DELMARVA			Date 2/23/12	20c. Location - City or Town, State DELMAR, DELAWARE	
		4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)								
		21. Signature of Funeral Service Licensee 			22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975					
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Intra cranial hemorrhage					Approximate Interval Between Onset and Death			
		b. Due to (or as a consequence of): Ischemic stroke.								
		c. Due to (or as a consequence of):								
		d. Due to (or as a consequence of):								
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown			23d. Date of delivery Month Day Year			
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown			
							23f. Was an autopsy performed? 1 Yes 2 No			
							23g. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No			
		25. Was case referred to medical examiner? 1 Yes 2 No		26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)			23h. Location (Street and Number or Rural Route Number, City or Town, State)			
		27. Manner of Death 1 Natural 5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 Yes 2 No	28d. Describe how injury occurred			
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						
		29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					29d. Date signed (Month, Day, Year) Feb 19 2012			
		29b. Signature and title of certifier 		29c. License number D68552						
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR FARHAD SADIQUE MD 100 E. Carroll St Salisbury MD 21801								
State Registrar		31. Date filed (Month, Day, Year) FEB 23 2012		32. Registrar's Signature 						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No. 2012 07540

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Yolande Marielle Carboneau				2. Date of Death Month Day Year February 29, 2012	3. Time of Death 11:40 PM
	4a. Facility Name (If not institution, give street and number) Envoy of Denton		4b. City, Town, or Location of Death Denton		4c. County of Death Caroline	
Funeral Director	5. Social Security Number 030-24-5593	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 78 Yrs.	If Under 1 Year Months Days Hours Min. 8. Date of Birth (Month, Day, Year) April 9, 1933	9. Birthplace (State or Foreign Country) Massachusetts	
	Usual Residence of Decedent 10a. State Maryland		10b. County Caroline	10c. City, Town or Location Denton		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
To Be Completed by Funeral Director	10e. Street and Number 24634 Pealiquor Road			10f. Zip Code 21629	10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: Elementary/Secondary (0-12) 8	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: College (1-4or 5+) Homemaker/waitressing	14. Race - American Indian, Black, White, etc. Specify: White
Physician /Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker/waitressing	16b. Kind of Business/Industry Family/food services	
	17. Father's Name (First, Middle, Last) Louis Armond Brouillard			18. Mother's Name (First, Middle, Maiden Surname) Leodina Constant		
Medical Certification: To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Susan Parenteau/daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24634 Pealiquor Road Denton, Maryland 21629		
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Randy P. Hock			20b. Place of Disposition (Name of cemetery, crematory or other place) Capitol Crematory	Date 3/2/2012	20c. Location - City or Town, State Denton, Maryland
Medical Certification: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Randy P. Hock			22. Name and Address of Facility Moore Funeral Home, P.A.		
				12 South Second Street	Denton, Maryland 21629	
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. end stage dementia Due to (or as a consequence of):						
b. _____ Due to (or as a consequence of):						
c. _____ Due to (or as a consequence of):						
d. _____						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
26. Place of Death Check only one Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)						
28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
29b. Signature and title of certifier Melinda Butler			29c. License number 00053255		29d. Date signed (Month, Day, Year) 3/1/2012	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Melinda Butler 3683 Chantek Rd Preston MD 21655						
31. Date filed (Month, Day, Year) MAR 02 2012		32. Registrar's Signature Amber A. Jones				

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1 - For
State
Registrar

Certificate of Death

Reg. No.

2012 07541

Physician/
Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

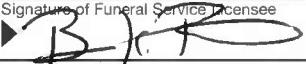
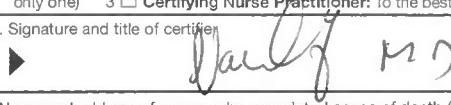
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

Physician/
Medical
Examiner

Permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

1. Decedent's Name (First, Middle, Last) Edgar Lee Cannon		2. Date of Death Month February Day 22 Year 2012		3. Time of Death 10:50 a M
4a. Facility Name (If not institution, give street and number) Dorchester General Hospital		4b. City, Town, or Location of Death Cambridge		4c. County of Death Dorchester
5. Social Security Number 217-28-2873		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months If Under 24 Hrs. Days Hours Min.
8. Date of Birth (Month, Day, Year) April 14, 1932		9. Birthplace (State or Foreign Country) Maryland		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
10a. State MD		10b. County Dorchester	10c. City, Town or Location Cambridge	
10e. Street and Number 5010 Bucktown Road		10f. Zip Code 21613		10g. Citizen of What Country? USA
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates. 1952-56		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: white
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) brick mason		16b. Kind of Business/Industry construction
17. Father's Name (First, Middle, Last) Charles Edgar Cannon		18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Thomas		
19a. Informant's Name/Relationship (Type, Print) Mary B. Cannon wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5010 Bucktown Road, Cambridge, MD 21613		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Cem		Date 2/29/12
20c. Location - City or Town, State Hurlock, MD				
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 21613		
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) end stage lung cancer		Approximate Interval Between Onset and Death		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. Due to (or as a consequence of): { b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown 3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (specify) _____		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> D.O.A Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year) 28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		
29c. License number D 47924		29d. Date signed (Month, Day, Year) 2-27-2012		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NORMAN THANHNY 503 BYRN ST CAMBRIDGE MD 21613				
31. Date filed (Month, Day, Year) FEB 28 2012		32. Registrar's Signature 		

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2012 07542

Certificate of Death

Reg. No.

1- For
State
Registrar

Physician/
Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department. If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

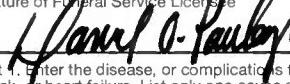
Physician/
Medical
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. Decedent's Name (First, Middle, Last) Alice E. Curtis							2. Date of Death Month February Day 23 , Year 2012	3. Time of Death 5:15 A M
4a. Facility Name (if not institution, give street and number) College View Nursing Center							4b. City, Town, or Location of Death Frederick	4c. County of Death Frederick
5. Social Security Number 577-01-5484		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) 92 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) Nov. 17, 1919	9. Birthplace (State or Foreign Country) Washington D.C.	
Usual Residence of Decedent Maryland		10a. State Maryland 10b. County Frederick		10c. City, Town or Location Keedysville			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 5001 Red Hill Road				10f. Zip Code 21756			10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			
14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 2			16b. Kind of Business/Industry Homemaker	
17. Father's Name (First, Middle, Last) Wilbur B. Townsend				18. Mother's Name (First, Middle, Maiden Surname) Julia A. Mealey				
19a. Informant's Name/Relationship (Type, Print) Eugene A. Curtis - Son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5001 Red Hill Road, Keedysville, Maryland 21756					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Mount Tabor UMC Cem.			Date Feb. 27, 2012	20c. Location - City or Town, State Etchison, Maryland	
21. Signature of Funeral Service Licensee  M01393			22. Name and Address of Facility Molesworth-Williams P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872					

23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)			Approximate Interval Between Onset and Death
<p>a. Cardiomyopathy Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>			

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No

25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA	26. Place of Death (Check only one) <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
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27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide	28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier 	29c. License number D60417	29d. Date signed (Month, Day, Year) February 23, 2012
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hemen Shah MD, 65c Thomas Johnson Dr, Frederick MD 21702	
31. Date filed (Month, Day, Year) FEB 24 2012	32. Registrar's Signature 

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07543

1 - For
State
RegistrarPhysician/
Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/
Medical
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

		1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death	
		FRANCIS W. CLARK		Month 02	Day 27	Year 2012 AM 0884M	
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death			
UNIVERSITY OF MARYLAND MEDICAL CENTER		BALTIMORE		Baltimore City			
5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	
212-24-1684		1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	85	Months	Days	Hours Min.	
9. Usual Residence of Decedent		10a. State		10b. County		10c. City, Town or Location	10d. Inside City Limits
		MD		Allegany		Frostburg	1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
10e. Street and Number		10f. Zip Code		10g. Citizen of What Country?			
13205 Upper Georges Creek Road		21532		United States			
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)		14. Race - American Indian, Black, White, etc.	
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No WW 2 If Yes, Give Year or Dates.		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		Specify: white	
15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry			
Elementary/Secondary (0-12) 12		College (1-4 or 5+) Construction Engineer		Highway Administration			
17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)					
Harry Alvin Clark		Alice Jane Kyle					
19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)					
Vicky Clark/daughter in law		9517 Dublin Road, Walkersville Maryland 21793					
20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date	20c. Location - City or Town, State		
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		Sunset Mem. Park		03/02/2012	Cumberland Maryland		
21. Signature of Funeral Service Licensee		22. Name and Address of Facility					
J. Wayne Bol		Boal Funeral Home		111 Church St, Westernport, Maryland 21562			
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.		23b. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.		Approximate Interval Between Onset and Death			
Immediate Cause (Final disease or condition resulting in death)		a. MULTI-ORGAN FAILURE Due to (or as a consequence of):					
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. ARTIFICIAL ABDOMINAL AORTIC ANEURYSM Due to (or as a consequence of):					
		c. Due to (or as a consequence of):					
		d. Due to (or as a consequence of):					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery		Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death?			
				1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one)		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
		Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DCA		Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work? M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred		
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
29a. Certifier (Check only one)		29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number			
				1518101088			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		31. Date filed (Month, Day, Year)		32. Registrar's Signature			
22 SOUTH GREENE ST BALTIMORE, MD 21201 MARIA KARLA VILLACIN		FEB 28 2012		James P. Smith			

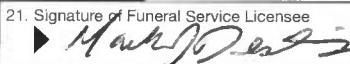
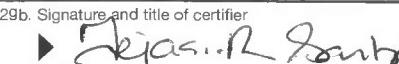
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07544

1 - For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Robert Dorsey Calp					2. Date of Death Month 03 Day 01 Year 2012	3. Time of Death 9:30 P M	
	4a. Facility Name (if not institution, give street and number) 1217 Cape Sable Drive			4b. City, Town, or Location of Death Westminster		4c. County of Death Carroll		
Funeral Director	5. Social Security Number 217-50-8907	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 63 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) 10/24/1948	9. Birthplace (State or Foreign Country) MD	
	Usual Residence of Decedent			Min.				
To Be Completed by Funeral Director	10a. State MD	10b. County Carroll	10c. City, Town or Location Westminster				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 1217 Cape Sable Drive		10f. Zip Code 21158			10g. Citizen of What Country? USA		
Physician/ Medical Examiner	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) financial administrator			16b. Kind of Business/Industry Northrup Grumman		
Medical Certificate: To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Charles W. Calp			18. Mother's Name (First, Middle, Maiden Surname) Retta Gertrude Wilhelm				
	19a. Informant's Name/Relationship (Type, Print) Michele E. Meyers Calp/wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1217 Cape Sable Drive, Westminster, MD 21158				
Physician/ Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lakeview Memorial Pk.		Date 03/07/2012	20c. Location - City or Town, State Sykesville, MD		
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Pritts Funeral Home and Chapel, PA 412 Washington Road, Westminster, MD 21157					
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pancreatic Cancer Due to (or as a consequence of): 1 year								
b. _____ Due to (or as a consequence of): _____								
c. _____ Due to (or as a consequence of): _____								
d. _____ Due to (or as a consequence of): _____								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 		29c. License number DC0711600			29d. Date signed (Month, Day, Year) 3/2/2012			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tejaswi R. Sastry, M.D., 10710 Charter Dr., Suite G20, Columbia, MD 21044								
31. Date filed (Mon. Day Year) MAR 12 2012		32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07545

1 - For
State
RegistrarPhysician/
Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

		1. Decedent's Name (First, Middle, Last) LEONA LORETTA CANOLES		2. Date of Death Month March Day 24 Year 2012		3. Time of Death 7:27 PM		
		4a. Facility Name (if not institution, give street and number) MERITUS MED. CENTER		4b. City, Town, or Location of Death HAGERSTOWN, MD		4c. County of Death WASHINGTON		
		5. Social Security Number 331-38-9891	6. Sex 1 M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) 12-27-1930	9. Birthplace (State or Foreign Country) VA
		10a. State MD		10b. County WASHINGTON		10c. City, Town or Location KEDYSVILLE		
		10e. Street and Number 5231 MT. BRIAR ROAD		10f. Zip Code 21756		10g. Citizen of What Country? USA		
		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) HOMEMAKER		16b. Kind of Business/Industry N/A		
		17. Father's Name (First, Middle, Last) DEWEY SOLOMON SMITH		18. Mother's Name (First, Middle, Maiden Surname) IVA ELTON DOVE				
		19a. Informant's Name/Relationship (Type, Print) HENRY B CANOLES / SON		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 60 Canoles LANE Berkeley SPRINGS, WV 25411				
		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Smithsburg Crematory		Date 3-9-12	20c. Location - City or Town, State Smithsburg, MD 21783	
		21. Signature of Funeral Service License John Anderson		22. Name and Address of Facility Hunter Anderson F.H. + Cremations		36 S Green St. Berkeley Springs WV 25411		
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Due to (or as a consequence of): Bowel Infarction		Approximate Interval Between Onset and Death		
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23c. Due to (or as a consequence of): Clostridium difficile colitis				
		23d. Due to (or as a consequence of): Respiratory Failure		23e. Due to (or as a consequence of): Sepsis				
		23f. Due to (or as a consequence of):		23g. Due to (or as a consequence of):				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 D7546

1- For
State
RegistrarPhysician/
Medical
Examiner

		1. Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death			
		MAYME ELIZABETH COOMBS				Month Day Year		11:08 a.m.			
		4a. Facility Name (If not Institution, give street and number)				4b. City, Town, or Location of Death		4c. County of Death			
		Civista Medical Center				La Plata		Charles			
Funeral Director		5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign Country)			
		214-32-9814	1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	81 Yrs.	Months	Days	(Month, Day, Year)	SEP. 19, 1930 MARYLAND			
		10a. State	10b. County	10c. City, Town or Location				10d. Inside City Limits			
		MD	CHARLES	POMFRET				1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
		10e. Street and Number				10f. Zip Code		10g. Citizen of What Country?			
		6670 BENSVILLE ROAD				20675		U. S. A.			
		11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)		14. Race - American Indian, Black, White, etc.			
		1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		Specify: WHITE			
		15. Decedent's Education (Specify only highest grade completed)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry			
		Elementary/Secondary (0-12) 7		College (1-4 or 5+) HOMEMAKER				OWN HOME			
		17. Father's Name (First, Middle, Last)				18. Mother's Name (First, Middle, Maiden Surname)					
		WILLIAM COLLIER				GOLDIE SHIFFLETT					
		19a. Informant's Name/Relationship (Type, Print)		DAUGHTER		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)					
		ELIZABETH A. BOWIE				6970 PORT TOBACCO RD, WELCOME, MD 20693					
		20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Date of death		20c. Location - City or Town, State			
		1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		MD VETS. CEMETERY		MARCH 8, 2012		CHELTENHAM, MD			
		21. Signature of Funeral Service Licensee		22. Name and Address of Facility		RAYMOND FUNL. SERVICE P.A.					
		<i>John Baile Soto</i>		MO0641		5635 WASHINGTON AVE., LA PLATA, MD 20646					
Physician/ Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				Approximate Interval Between Onset and Death					
		Immediate Cause (Final disease or condition resulting in death)									
		a. Due to (or as a consequence of): <i>Respiratory failure</i>									
		b. Due to (or as a consequence of): <i>Pneumonia</i>									
		c. Due to (or as a consequence of): <i>Aspiration</i>									
		d. Due to (or as a consequence of): <i>Bronchomalacia</i>									
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year					
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Sepsis</i>				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
										28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
		29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						28f. Location (Street and Number or Rural Route Number, City or Town, State)			
		29b. Signature and title of certifier <i>John Omais</i>		29c. License number D-57708		29d. Date signed (Month, Day, Year) 03-02-2012					
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)									
		Abbas Omais MD, Cenna Medical Center 7C Post Office Rd						Waldorf, MD 20602			
		31. Date filed (Month, Day, Year) MAR 12 2012		32. Registrar's Signature <i>John J. Omais</i>							

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State of Maryland / Department of Health and Mental Hygiene

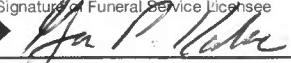
Certificate of Death

Reg. No. 2012 07547

1 - For
State
Registrar

Physician/
Medical
Examiner

Baltimore, Maryland 21215-0036
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death	
Tina Clark - Dorsey		Month February Day 24, 2012		Year 8:30 A.M.	
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death	
Springbrook Adventist Nursing & Rehab.		Silver Spring		Montgomery	
5. Social Security Number 577-90-5278		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F Yrs. 51		7. Age (In yrs. last birthday) If Under 1 Year Months If Under 24 Hrs. Days Hours Min. 8. Date of Birth (Month, Day, Year) 07/31/1960	
Usual Residence of Decedent				9. Birthplace (State or Foreign Country) Maryland	
10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Temple Hills	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
10e. Street and Number 4904 Brentley Road		10f. Zip Code 20748		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Manager		16b. Kind of Business/Industry Gift Shop	
17. Father's Name (First, Middle, Last) Theodore Johnson		18. Mother's Name (First, Middle, Maiden Surname) Claudette Clark			
19a. Informant's Name/Relationship (Type, Print) Tara Clark / Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4904 Brentley Road Temple Hills, Maryland 20748			
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Kalas Crematory		Date 02/28/2012	20c. Location - City or Town, State Edgewater, Maryland
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd., Oxon Hill, MD 20745			

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Due to (or as a consequence of): Cardiomyopathy		Approximate Interval Between Death and Death 3 Months	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23c. Due to (or as a consequence of): a. _____			
		b. _____			
		c. _____			
		d. _____			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Aids, Anemia , HTN		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year) 28b. Time of injury M 28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. B <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier 		29c. License number D28656		29d. Date signed (Month, Day, Year) 2/24/2012	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ravi Passi, M.D., 15245 Shady Grove Rd., #130, Rockville, MD 20850					
31. Date filed (Month, Day, Year) FEB 28 2012		32. Registrar's Signature 			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07568

**1 - For
State
Registrar**

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) Riec Eileen Canjar						2. Date of Death Month 02 Day 23 Year 2012			3. Time of Death 8:30p.M					
Funeral Director		4a. Facility Name (if not institution, give street and number) 12010 Patuxent Pkwy Unit -F						4b. City, Town, or Location of Death Columbia			4c. County of Death Howard					
To Be Completed by Funeral Director		5. Social Security Number 546-90-4433		6. Sex M		7. Age (In yrs. last birthday) 61 Yrs.		If Under 1 Year Months Days Hours Min.		8. Date of Birth (Month, Day, Year) 12-18-1950		9. Birthplace (State or Foreign Country) California				
To Be Completed by Funeral Director		10a. State MD		10b. County Howard		10c. City, Town or Location Columbia					10d. Inside City Limits Yes					
To Be Completed by Physician/Medical Examiner		10e. Street and Number 12010 Patuxent Pkwy Unit-F						10f. Zip Code 21044			10g. Citizen of What Country? United States					
To Be Completed by Physician/Medical Examiner		11. Marital Status Never Married			12. Was Decedent Ever in U.S. Armed Forces? Yes			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) No			14. Race - American Indian, Black, White, etc. Black					
To Be Completed by Physician/Medical Examiner		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)			16b. Kind of Business/Industry Senior Analyst								
To Be Completed by Physician/Medical Examiner		17. Father's Name (First, Middle, Last) Herbert Wirtz						18. Mother's Name (First, Middle, Maiden Surname) Jetta Whitfield								
To Be Completed by Physician/Medical Examiner		19a. Informant's Name/Relationship (Type, Print) Cecelia E. Wirtz/Sister						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 615 Emerson Street NW Washington DC 20011								
To Be Completed by Physician/Medical Examiner		20a. Method of Disposition Burial			20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory			Date 2-25-2012		20c. Location - City or Town, State Beltsville, Maryland						
To Be Completed by Physician/Medical Examiner		21. Signature of Funeral Service Licensee John T. Rhines Funeral Home			22. Name and Address of Facility 3005 12th Street NE Washington DC 20017											
To Be Completed by Physician/Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last														
To Be Completed by Physician/Medical Examiner		a. Hypertension Due to (or as a consequence of): b. Diabetes Mellitus Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____														
To Be Completed by Physician/Medical Examiner		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? Yes		23c. If yes, outcome of pregnancy Live Birth						23d. Date of delivery Month Day Year						
To Be Completed by Physician/Medical Examiner		23b. Was decedent pregnant in the past 12 months? Yes		23c. If yes, outcome of pregnancy Live Birth						23d. Date of delivery Month Day Year						
To Be Completed by Physician/Medical Examiner		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Obesity, Seizure Disorders, Pulmonary Embolism														
To Be Completed by Physician/Medical Examiner		23e. Did tobacco use contribute to the cause of death? Yes														
To Be Completed by Physician/Medical Examiner		24a. Was an autopsy performed? Yes						24b. Were autopsy findings available prior to completion of cause of death? Yes								
To Be Completed by Physician/Medical Examiner		25. Was case referred to medical examiner? Yes						26. Place of Death (Check only one) Inpatient								
To Be Completed by Physician/Medical Examiner		Hospital: ER/Outpatient						Other: Nursing Home								
To Be Completed by Physician/Medical Examiner		27. Manner of Death Natural			28a. Date of injury (Month, Day, Year)			28b. Time of injury M			28c. Injury at work? Yes			28d. Describe how injury occurred		
To Be Completed by Physician/Medical Examiner		27. Manner of Death Natural			28a. Date of injury (Month, Day, Year)			28b. Time of injury M			28c. Injury at work? Yes			28d. Describe how injury occurred		
To Be Completed by Physician/Medical Examiner		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)								
To Be Completed by Physician/Medical Examiner		29a. Certifier Certifying Physician : To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner : On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner : To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						29c. License number D28998						29d. Date signed (Month, Day, Year) Feb 24, 2012		
To Be Completed by Physician/Medical Examiner		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pritam S. Saini, M.D.														
To Be Completed by Physician/Medical Examiner		31. Date filed (Month, Day, Year) FEB 28 2012						32. Registrar's Signature S. Parker								

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

**State
Registrar**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07549

1 - For
State
Registrar

Physician/
Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

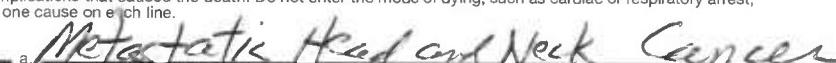
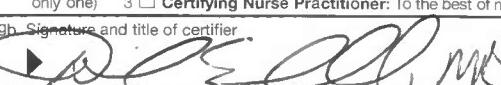
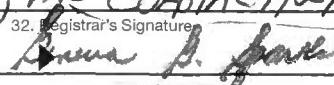
Physician/
Medical
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year				3. Time of Death 10:25p M		
Braxton L. Clark			2 18 2012						
4a. Facility Name (if not institution, give street and number)			4b. City, Town, or Location of Death				4c. County of Death		
721 Dennis Street			Salisbury				Wicomico		
5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 61 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) 6-21-1950	9. Birthplace (State or Foreign Country) MD		
218-48-7873 Usual Residence of Decedent									
10a. State MD	10b. County Wicomico	10c. City, Town or Location Salisbury				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number 721 Dennis Street			10f. Zip Code 21801			10g. Citizen of What Country? USA			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No Navy If Yes, Give Year or Dates. 4/1970		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Pastor		16b. Kind of Business/Industry Self-Employed					
17. Father's Name (First, Middle, Last) Jim Clark				18. Mother's Name (First, Middle, Maiden Surname) Frances Bishop					
19a. Informant's Name/Relationship (Type, Print) Melinda Smiley/Daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 501 Hollybrook Apts, Laurel, DE19956						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) MD Veteran's Cem			Date 2-27-2012	20c. Location - City or Town, State Hurlock, MD		
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Bennie Smith 917 W. Isabella St. Funeral Home Salisbury, MD 21801						
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)			Approximate Interval Between Onset and Death  Due to (or as a consequence of):						
Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined			28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred			
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier 			29c. License number 026278			29d. Date signed (Month, Day, Year) 2-20-12			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID COOK, MD COASTAL HOSPICE PO BOX 1733 SALISBURY, MD 21802									
31. Date filed (Month, Day, Year) FEB 22 2012			32. Registrar's Signature 						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07550

1 - For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) JIMMY LEE DAVIS, SR.					2. Date of Death Month FEB Day 23 Year 2012	3. Time of Death 08:02 AM				
	4a. Facility Name (if not institution, give street and number) ATLANTIC GENERAL HOSPITAL			4b. City, Town, or Location of Death BERLIN, MARYLAND		4c. County of Death WORCESTER					
Funeral Director	5. Social Security Number 215-38-1995	6. Sex 1 X M 2 F	7. Age (In yrs. last birthday) 69 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) DEC 30, 1942	9. Birthplace (State or Foreign Country) BERLIN, MD				
	10a. State DELAWARE			10b. County SUSSEX COUNTY	10c. City, Town or Location DAGSBORO			10d. Inside City Limits 1 □ Yes 2 X No			
To Be Completed by Funeral Director	10e. Street and Number 22 HOLIDAY ESTATES			10f. Zip Code 19939			10g. Citizen of What Country? UNITED STATES				
	11. Marital Status 1 □ Never Married 2 X Married 3 □ Widowed 4 □ Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 X No If Yes, Give Year or Dates. 8		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 X No Specify: MECHANIC		14. Race - American Indian, Black, White, etc. Specify: WHITE				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)		16b. Kind of Business/Industry AUTO REPAIR						
	17. Father's Name (First, Middle, Last) CARLTON HENRY DAVIS				18. Mother's Name (First, Middle, Maiden Surname) BERNICE MAE BROWN						
	19a. Informant's Name/Relationship (Type, Print) SHIRLEY DAVIS (SPOUSE)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22 HOLIDAY ESTATES, DAGSBORO, DE 19939							
	20a. Method of Disposition 1 □ Burial 2 X Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) MO 1361		20b. Place of Disposition (Name of cemetery, crematory or other place) FIRST STATE CREM.CTR.		Date FEB 27, 2012	20c. Location - City or Town, State MILLSBORO, DE					
	21. Signature of Funeral Service Licensee Robert [Signature]		22. Name and Address of Facility WATSON FUNERAL HOME MILLSBORO, DELAWARE 19966								
Physician/ Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Large and small bowel infarction							Approximate Interval Between Onset and Death			
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Atrial Fibrillation.										
	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown							23c. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown	23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 X Probably 4 □ Unknown			
								24a. Was an autopsy performed? 1 □ Yes 2 X No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No		
	25. Was case referred to medical examiner? 1 □ Yes 2 X No							26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)			
	27. Manner of Death 1 X Natural 5 □ Pending Investigation 2 □ Accident 6 □ Could not be determined							28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 □ Yes 2 □ No	28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 □ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							29b. Signature and title of certifier M.D			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Atif Zeehan ACT 9733 Health Way Drive Berlin MD 21801							29c. License number DO064120	29d. Date signed (Month, Day, Year) 02/23/2012		
State Registrar	31. Date filed (Month, Day, Year) FEB 27 2012		32. Registrar's Signature Anna J. Davis								

Jimmy L Davis DOB 12/30/1942 DOD 2/23/2012 TDD 0802

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

BA 5

State
Registrar

DHMH 17 Rev 06-2011

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2012 07551

Certificate of Death

Reg. No.

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) Katherine Todd Dean				2. Date of Death Month Day Year February 22 2012 00259 M		3. Time of Death		
		4a. Facility Name (if not institution, give street and number) Dorchester General Hospital				4b. City, Town, or Location of Death Cambridge		4c. County of Death Dorchester		
Funeral Director		5. Social Security Number 218-24-5330		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days Hours Min.		8. Date of Birth (Month, Day, Year) Feb. 9, 1930	9. Birthplace (State or Foreign Country) Maryland	
		10a. State MD		10b. County Dorchester		10c. City, Town or Location Cambridge				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
To Be Completed by Funeral Director		10e. Street and Number 205 Choptank Avenue				10f. Zip Code 21613		10g. Citizen of What Country? USA		
		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white		
To Be Completed by Funeral Director		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) pattern maker		16b. Kind of Business Industry garment mfg.				
		17. Father's Name (First, Middle, Last) unknown				18. Mother's Name (First, Middle, Maiden Surname) Alice Todd				
Physician/ Medical Examiner		19a. Informant's Name/Relationship (Type, Print) Frances E. Kuhn daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 205 Choptank Avenue, Cambridge, MD 21613					
		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Cem.		Date 2/27/12	20c. Location - City or Town, State Hurlock, MD		
Physician/ Medical Examiner		21. Signature of Funeral Service Licensee B. E. Kuhn				22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 21613				
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)				Approximate Interval Between Onset and Death				
Physician/ Medical Examiner		23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown				
		23d. Date of delivery Month Day Year								
Physician/ Medical Examiner		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
Physician/ Medical Examiner		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
Physician/ Medical Examiner		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
Physician/ Medical Examiner		29a. Certifier <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> only one <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier Eugene Novak Jr. DO				
						29c. License number H5993				
Physician/ Medical Examiner		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eugene Novak Jr. DO 321 Dorchester Ave, Suite Cambridge MD 21613				29d. Date signed (Month, Day, Year) 9/22/12				
State Registrar		31. Date filed (Month, Day, Year) FEB 24 2012		32. Registrar's Signature Jane J. Pace						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 24a per med cert G925 3/14/12 dk
State of Maryland / Department of Health and Mental Hygiene

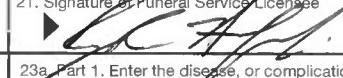
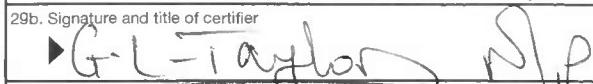
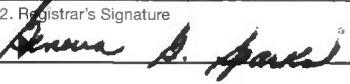
Certificate of Death

Reg. No.

2012 07552

1 - For
State
Registrar

Physician/
Medical
Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death Hour Minute AM PM	
CAROL L. DOFFLEMYER		21 18 2012		8 A M	
4a. Facility Name (if not institution, give street and number) 1976 SCOTTS CROSSING WAY UNIT 104		4b. City, Town, or Location of Death ANNAPOLIS		4c. County of Death ANNE ARUNDEL	
5. Social Security Number 216-38-0519		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F 7. Age (In yrs. last birthday) 70 Yrs.		If Under 1 Year Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 1/12/1942	
10a. State MD		10b. County ANNE ARUNDEL		10c. City, Town or Location ANNAPOLIS	
10d. Inside City Limits 1 X Yes 2 <input type="checkbox"/> No					
10e. Street and Number 1976 SCOTTS CROSSING WAY UNIT 104		10f. Zip Code 21401		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: WHITE	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 1		16b. Kind of Business/Industry MANAGER	
17. Father's Name (First, Middle, Last) FRANKLIN LEIGER		18. Mother's Name (First, Middle, Maiden Surname) VIRGINIA RUTH			
19a. Informant's Name/Relationship (Type, Print) WILLIAM DOFFLEMYER		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1976 SCOTTS CROSSING WAY UNIT 104 ANNAPOLIS, MD 21401			
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) CHESAPEAKE CREMATION CENTER		20b. Place of Disposition (Name of cemetery, crematory or other place) CHESAPEAKE CREMATION CENTER		Date 2/23/2012	20c. Location - City or Town, State STEVENSVILLE
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility LASTING TRIBUTES CREMATION & FUNERAL CARE FELLOWS, HELFENBEIN & NEWNAM 814 BESTGATE ROAD ANNAPOLIS, MD 21401			
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death			
a. Due to (or as a consequence of): CHRONIC OBSTRUCTIVE PULMONARY YEARS					
b. Due to (or as a consequence of):					
c. Due to (or as a consequence of):					
d. Due to (or as a consequence of):					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year) M		28b. Time of Injury M	
		28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input checked="" type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier 		29c. License number R118703		29d. Date signed (Month, Day, Year) 2/20/2012	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GENEVIEVE L-TAYLOR, 445 DEFENSE HWY, ANNAPOLIS, MD 21401					
31. Date filed (Month, Year) FEB 21 2012		32. Registrar's Signature 			

Baltimore, Maryland 21215-0036

Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

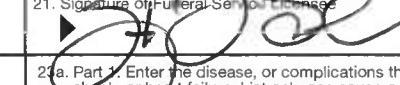
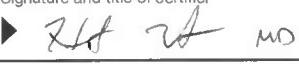
State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07553

1 - For State Registrar		1. Decedent's Name (First, Middle, Last) Doris M Dittman							2. Date of Death Month 03 Day 04 Year 2012		3. Time of Death 02:33 AM	
Physician/ Medical Examiner		4a. Facility Name (if not institution, give street and number) University of Maryland Medical Center			4b. City, Town, or Location of Death Baltimore			4c. County of Death /				
Funeral Director		5. Social Security Number 222-16-8338		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) Jan. 12 1929		
To Be Completed by Funeral Director		9. Birthplace (State or Foreign Country) Delaware										
10a. State MD		10b. County Caroline		10c. City, Town or Location Marydel			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number 18240 Lepore Rd.		10f. Zip Code 21649			10g. Citizen of What Country? U.S.A.							
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: /			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: /			14. Race - American Indian, Black, White, etc. Specify: White				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Homemaker			16b. Kind of Business/Industry Own Home							
17. Father's Name (First, Middle, Last) William Albert Biger		18. Mother's Name (First, Middle, Maiden Surname) Aliza Wheatman										
19a. Informant's Name/Relationship (Type, Print) William A. Dittman (son)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16 Legend Lane Houston, DE. 19954										
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) /		20b. Place of Disposition (Name of cemetery, crematory or other place) Kent Cremation Services			Date 3/5/12		20c. Location - City or Town, State Smyrna, DE.					
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Faries Funeral Home 29 South Main St. Smyrna, DE. 19977										
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Due to (or as a consequence of): lactic acidosis			Approximate Interval Between Onset and Death							
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23c. Due to (or as a consequence of): /			/							
23d. Date of delivery Month Day Year		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown										
23f. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Renal failure		23g. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			23h. Location (Street and Number or Rural Route Number, City or Town, State) /							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State) /							
29b. Signature and title of certifier 		29c. License number 1316262876			29d. Date signed (Month, Day, Year) March 04, 2012							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hariatha Katalam 39W Lexington St. Apt. B05 Baltimore, MD 21201												
31. Date filed (Month, Day, Year) MAR 12 2012		32. Registrar's Signature 										

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

**State
Registrar**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

2012 07554

1 - For
State
RegistrarPhysician/
Medical
ExaminerFuneral
Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. Decedent's Name (First, Middle, Last)		Pamela Kay Deltuva		2. Date of Death Month Day Year	3. Time of Death 15:14 PM
4a. Facility Name (if not institution, give street and number) The Johns Hopkins Hospital		4b. City, Town, or Location of Death Baltimore City		4c. County of Death None	
5. Social Security Number 214-44-5050 Usual Residence of Decedent		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 65 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 07/16/1946
10a. State MD	10b. County Howard	10c. City, Town or Location Ellicott City			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
10e. Street and Number 9401 Furrow Avenue			10f. Zip Code 21042		10g. Citizen of What Country? United States
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Analyst		16b. Kind of Business/Industry FBI
17. Father's Name (First, Middle, Last) Harold Wallace				18. Mother's Name (First, Middle, Maiden Surname) Mary Snyder	
19a. Informant's Name/Relationship (Type, Print) Robert Deltuva - Husband			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9401 Furrow Avenue Ellicott City, MD 21042		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) ► <i>Shawn Collins - wife</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) Crest Lawn Mem.		Date 03-02-2012	20c. Location - City or Town, State Marriottsville, MD
21. Signature of Funeral Service Licensee ► <i>Shawn Collins - wife</i>		22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043			
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Due to (or as a consequence of): <i>Coronary Artery Disease</i>			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23c. Due to (or as a consequence of):			
		23d. Due to (or as a consequence of):			
		23e. Approximate Interval Between Onset and Death			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		23f. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier ► <i>J. B.</i>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KIRNELA BYKU		29c. License number RES-000		29d. Date signed (Month, Day, Year) February 27, 2012	
31. Date filed (Month, Day, Year) FEB 28 2012		32. Registrar's Signature Anna S. Park			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07555

1 - For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Mercedes Estrada							2. Date of Death Month Day Year February 21, 2012	3. Time of Death 0112 A M	
	4a. Facility Name (if not institution, give street and number) 10125 Clearspring Road				4b. City, Town, or Location of Death Damascus			4c. County of Death Montgomery		
Funeral Director	5. Social Security Number Non-US Citizen		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) Aug. 9, 1930	9. Birthplace (State or Foreign Country) E1 Salvador		
To Be Completed by Funeral Director	10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Damascus			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number 10125 Clearspring Road				10f. Zip Code 20872			10g. Citizen of What Country? E1 Salvador		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify: E1 Salvadorian			14. Race - American Indian, Black, White, etc. Specify: Hispanic		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business Industry Own Home					
	17. Father's Name (First, Middle, Last) Steban Estrada				18. Mother's Name (First, Middle, Maiden Surname) Sabastiana Estrada					
	19a. Informant's Name/Relationship (Type, Print) Eva Estrada, Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10125 Clearspring Road, Damascus, MD 20872							
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) All Souls		Date Feb. 23, 2012	20c. Location - City or Town, State Germantown, Maryland				
	21. Signature of Funeral Service Licensee  Mo1393		22. Name and Address of Facility Molesworth-Williams, P.A., Funeral Home 26401 Ridge Road, Damascus, MD 20872							
Physician/ Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Alzheimer's Disease								Approximate Interval Between Onset and Death Years	
	<p>a. Due to (or as a consequence of): Alzheimer's Disease</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>									
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year					
Medical Certificate To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Peripheral Vascular Disease								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred				
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number D42046		29d. Date signed (Month, Day, Year) February 22, 2012					
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Grace Brooke Huffman, M.D. 18100 Slade School Road Sandy Spring, Maryland 20860		31. Date filed (Month, Day, Year) FEB 23 2012		32. Registrar's Signature 					

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07556

1 - For
State
Registrar

Physician/
Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

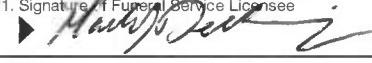
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/
Medical
Examiner

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month 03	Day 04	Year 2012	3. Time of Death 5:25 A ^M				
Gertrude Virginia Eanes			Westminster			Carroll				
4a. Facility Name (if not institution, give street and number) Carroll Hospice Dove House			4b. City, Town, or Location of Death Westminster			4c. County of Death Carroll				
5. Social Security Number 219-80-4871		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 94 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) 10/03/1917	9. Birthplace (State or Foreign Country) WV			
10a. State MD		10b. County Carroll		10c. City, Town or Location Westminster			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number 654 Ridge Road			10f. Zip Code 21157			10g. Citizen of What Country? USA				
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) homemaker			16b. Kind of Business/Industry own home				
17. Father's Name (First, Middle, Last) Troy Vinson Taylor				18. Mother's Name (First, Middle, Maiden Surname) Bany Rosa Taylor						
19a. Informant's Name/Relationship (Type, Print) Ronald Eanes/son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Box 59A, Albright, WV 26519						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Lake View Memorial Pk.			Date 03/08/2012	20c. Location - City or Town, State Sykesville, MD			
21. Signature of Funeral Service Licensee 			22. Name and Address of Funeral Home Pritts Funeral Home and Chapel, P.A. 412 Washington Road, Westminster, MD 21157							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)			23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Underlying Cause (Disease or injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death	
<p>a. Due to (or as a consequence of): <i>Causes of death</i></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Atrial fibrillation</i>			23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOD Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) HOSPICE							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred <i>Hospital</i>				
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29c. License number D 35378			29d. Date signed (Month, Day, Year) 03-04-12				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Flavio Kruter, M.D., 555 S. Center St., Westminster, MD 21157										
31. Date filed (Month, Day, Year) MAR 12 2012			32. Registrar's Signature <i>James J. Parker</i>							

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2012 07557

1-For State Registrar

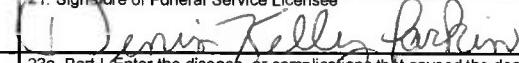
Reg. No.

Physician/Medical Examiner**Funeral Director****To Be Completed by Funeral Director****Baltimore, MD 21215-0036**

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/Medical Examiner**Medical Certification: To Be Completed by Physician/Medical Examiner****Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

1. Decedent's Name (First, Middle, Last)				2. Date of Death Month Day Year	3. Time of Death 1808 hrs
Lynda Hirst Evers				February 17, 2012	
4a. Facility Name (if not institution, give street and number) 30101 Niblett Court			4b. City, Town, or Location of Death Delmar		4c. County of Death Wicomico
5. Social Security Number 215-80-8069		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 53 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (MM/DD/YYYY) 1-21-1959
9. Birthplace (State or Foreign Country) New Jersey					
Usual Residence of Decedent					
10a. State MD	10b. County Wicomico	10c. City, Town or Location Delmar			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number 30101 Niblett Court			10f. Zip Code 21875		10g. Citizen of What Country? USA
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 2		16b. Kind of Business/Industry Disability Disabled	
17. Father's Name (First, Middle, Last) Franklin Strause Hirst			18. Mother's Name (First, Middle, Maiden Surname) Jean Verna MacIntyre		
19a. Informant's Name/Relationship (Type, Print) Kristen Hinman - Daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9558 Moonrider Lane, Columbia, Maryland 21046		
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:		20b. Place of Disposition (Name of cemetery, crematory or other place) Crematory of Delmarva		Date 2-20-2012	20c. Location - City or Town, State Delmar, Delaware
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
a. Hypertensive Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):					
b. Due to (or as a consequence of):					
c. Due to (or as a consequence of):					
d. Due to (or as a consequence of):					
<input checked="" type="checkbox"/> UNPENDED		<input checked="" type="checkbox"/> AMENDED 1 as noted, 23a,27 per me g925 3-27-12 vt			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input checked="" type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
					28d. Describe how injury occurred
					28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
					28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. one) 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 			29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) February 18, 2012
30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223					
31. Date filed (Month, Day, Year) FEB 22 2012		32. Registrar's Signature 			

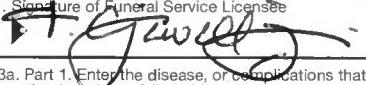
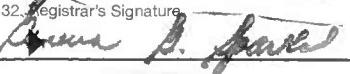
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07558

1 - For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Dale A. Evans					2. Date of Death Month 02 Day 17 Year 2012	3. Time of Death 0858 M
	4a. Facility Name (if not institution, give street and number) Peninsula Regional Medical Center		4b. City, Town, or Location of Death Salisbury			4c. County of Death Wicomico	
Funeral Director	5. Social Security Number 214-42-8353	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 69 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Feb. 19, 1942	9. Birthplace (State or Foreign Country) Maryland	
	10a. State MD		10b. County Wicomico		10c. City, Town or Location Salisbury		
To Be Completed by Funeral Director	10e. Street and Number 4348 Snow Hill Road			10f. Zip Code 21804		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 1960- If Yes, Give Year or Dates 1964	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. white			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) equipment operator	16b. Kind of Business/Industry county roads				
	17. Father's Name (First, Middle, Last) Oland Evans			18. Mother's Name (First, Middle, Maiden Surname) Evelyn Griffin			
	19a. Informant's Name/Relationship (Type, Print) Virginia Wilson Evans (Wife)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4348 Snow Hill Road Salisbury, MD 21804				
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Crematory of Delmarva		20b. Place of Disposition (Name of cemetery, crematory or other place) Crematory of Delmarva		Date 2-20-2012	20c. Location - City or Town, State Delmar, Delaware	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Short Funeral Home 13 E. Grove Street		Approximate Interval Between Onset and Death		
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Due to (or as a consequence of): Atherosclerotic Cardiovascular Disease				
	23c. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		23d. Due to (or as a consequence of):				
	23e. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23f. 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year		
	23g. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hepatic failure Renal failure		23h. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
	23i. 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		23j. 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Pending <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number D 345 93	29d. Date signed (Month, Day, Year) 2/17/2012	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nicholas L. Ogburn 100 E. Carroll St. Salisbury MD 21801		31. Date filed (Month, Day, Year) FEB 22 2012		32. Registrar's Signature 		

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner
State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1 - For
State
Registrar

Reg. No. 2012 07560

2. Date of Death
Month Day Year
February 27 2012

3. Time of Death
12:25 A M

Physician/
Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) Thomas Douglas Feehely			2. Date of Death Month Day Year February 27 2012	3. Time of Death 12:25 A M
4a. Facility Name (if not institution, give street and number) 16905 Heritage Hills Lane			4b. City, Town, or Location of Death Henderson	
4c. County of Death Caroline				
5. Social Security Number 214-52-9861	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 61 Yrs.	If Under 1 Year Months 0	If Under 24 Hrs. Days 0
			Hours 0	Min. 0
8. Date of Birth (Month, Day, Year) July 22 1950			9. Birthplace (State or Foreign Country) Maryland	
10a. State Maryland			10b. County Caroline	
10c. City, Town or Location Henderson			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 16905 Heritage Hills Lane			10f. Zip Code 21640	10g. Citizen of What Country? USA
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) master electrician		16b. Kind of Business Industry construction
17. Father's Name (First, Middle, Last) Leo H. Feehely, Sr.			18. Mother's Name (First, Middle, Maiden Surname) Dorothy Brady	
19a. Informant's Name/Relationship (Type, Print) Kimberly Wolf/ sister			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16905 Heritage Hills Ln.; Henderson, MD 21640	
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Cremation	Date Feb. 28 2012
21. Signature of Funeral Service Licensee 			20c. Location - City or Town, State Stevensville, MD	
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility PO Box 160; Greensboro, PA 21639 Fleegle and Helfenbein Funeral Home, PA	

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death
a. metastatic colon cancer Due to (or as a consequence of):		
b. _____ Due to (or as a consequence of):		
c. _____ Due to (or as a consequence of):		
d. _____		

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide	28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No
	28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)	

29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier 	29c. License number DOO6409	29d. Date signed (Month, Day, Year) Feb. 27, 2012
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Qiwei Gai, MD, 8221 Teal Dr; Su 302, Easton, MD 21601	
31. Date filed (Month, Day, Year) FEB 29 2012	32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07561

1 - For
State
Registrar

1. Decedent's Name (First, Middle, Last)

William Hughes Foster

2. Date of Death

Month Day

Year

3. Time of Death

1:40 A M

Physician/
Medical
Examiner

Baltimore, Maryland 21215-0036
Department of Health and Mental Hygiene
Important: If item 27 is marked other than "natural", or items 28a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Physician/
Medical
Examiner

Foster, William H.
Division of Vital Records, P.O. Box 68760
To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

To Be Completed by Funeral Director

4a. Facility Name (if not institution, give street and number)

Atlantic General Hospital

4b. City, Town, or Location of Death

Berlin

4c. County of Death

Worcester

Funeral
Director

5. Social Security Number

211-36-3257

6. Sex

M F

7. Age (In yrs. last birthday)

65

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)

08/17/1946

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

MD

10b. County

Worcester

10c. City, Town or Location

Berlin

10d. Inside City Limits

Yes No

10e. Street and Number

330 William St.

10f. Zip Code

21811

10g. Citizen of What Country?

USA

11. Marital Status

Never Married Married
 Widowed Divorced

12. Was Decedent Ever in U.S. Armed Forces?

Yes No
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Yes No
Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Administrator

16b. Kind of Business/Industry

Federal Govt. (NRC)

17. Father's Name (First, Middle, Last)

William Foster

18. Mother's Name (First, Middle, Maiden Surname)

Beth Hughes

19a. Informant's Name/Relationship (Type, Print)

Eleanor R. Foster

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

330 William St. Berlin, MD 21811

20a. Method of Disposition

Burial Cremation Removal from State
 Donation Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

First State Crematory

Date

2/27/2012

20c. Location - City or Town, State

Millsboro, DE

21. Signature of Funeral Service Licensee

John Burbage

22. Name and Address of Facility

The Burbage Funeral Home

108 William St. Berlin, MD 21811

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause for each line.

Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death

a. Due to (or as a consequence of):

Acute Col Gastrointestinal Bleeding

b. Due to (or as a consequence of):

Anemia

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
 Yes No
 Unknown

23c. If yes, outcome of pregnancy
 Live Birth Fetal death Ectopic pregnancy
 Pregnant at time of death Other (specify)
 Unknown

23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

Yes No Probably Unknown

25. Was case referred to medical examiner?

Yes No

Hospital:

Inpatient ER/Outpatient DOA

Other:

Nursing Home Residence Other (Specify)

27. Manner of Death

Natural Pending Investigation
 Accident Could not be determined
 Suicide Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work?

28d. Describe how injury occurred

M

Yes

No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Edward J. Brown

29c. License number

D46257

29d. Date signed (Month, Day, Year)

2-25-2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Edward J. Brown 10324 Old Cemetery Blvd. Berlin, MD 21811

31. Date filed (Month, Day, Year)

FEB 27 2012

32. Registrar's Signature

Anna S. Davis

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

For
State
Registrar

Reg. No.

2012 07562

Physician/
Medical
Examiner

1. Decedent's Name (First, Middle, Last) Juan Ferrufino				2. Date of Death Month 02 Day 19 Year 2012			3. Time of Death 9:10 P M
4a. Facility Name (if not institution, give street and number) Washington Adventist Hospital				4b. City, Town, or Location of Death Takoma Park			4c. County of Death Montgomery

Baltimore, Maryland 21215-0036
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland
Department. If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completed filled in by the funeral director, page 2 should be detached for use as the burial-transit
X

Funeral
Director

To Be Completed by Funeral Director

5. Social Security Number 577-06-3794	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 53 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 02/26/1958	9. Birthplace (State or Foreign Country) E1 Salvador	
Usual Residence of Decedent 10a. State MD				10b. County Prince Georges 10c. City, Town or Location Adelphi			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number 1801 Metzerott Road				10f. Zip Code 20783			10g. Citizen of What Country? El Salvador
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify: Salvadoran			14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housekeeping			16b. Kind of Business Industry Hotel
17. Father's Name (First, Middle, Last) Unknown				18. Mother's Name (First, Middle, Maiden Surname) Eva Cristina Ferrufino			
19a. Informant's Name/Relationship (Type, Print) Bertila Argueta (wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 749 Irving St., NW Washington, DC 20010			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven			Date 2/25/12
21. Signature of Funeral Service Licensee Wanda C. Bacon				22. Name and Address of Facility W.H. Bacon Funeral Home 3447 14th St NW Washington, DC 20010			

Physician/
Medical
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sepsis				Approximate Interval Between Onset and Death
a. Due to (or as a consequence of): Bilateral Aspiration Pneumonia b. Due to (or as a consequence of): Cardiovascular Accident. c. Due to (or as a consequence of): d.				
23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) _____
				23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Renal Failure Stage IV Diabetes Mellitus Type II Atherosclerotic Cardiovascular Disease				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No
		28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. Signature and title of certifier MD		29c. License number 47867		29d. Date signed (Month, Day, Year) 21/20/2012
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vince Lingo 4701 Randolph Rd #316, Rockville MD 20850				
31. Date filed (Month, Day, Year) FEB 24 2012		32. Registrar's Signature James S. Parker		

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07563

1 - For
State
Registrar

Physician/
Medical
Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death	3. Time of Death
Frederick Michael Frank, Jr.	Month February	Year 20, 2012
4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
3205 Kilkenny Street	Silver Spring	Montgomery

Funeral
Director

5. Social Security Number	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 65 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month Day, Year) July 20, 1946	9. Birthplace (State or Foreign Country) Washington, DC
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Usual Residence of Decedent
10a. State
Maryland
10b. County
Montgomery
10c. City, Town or Location
Silver Spring
10d. Inside City Limits
1 Yes 2 No

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

10e. Street and Number 3205 Kilkenny Street	10f. Zip Code 20904	10g. Citizen of What Country? United States
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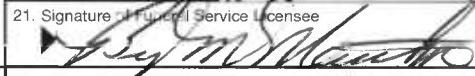
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates Vietnam War	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: White
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15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 1-4	16b. Kind of Business Industry I.T. Specialist
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17. Father's Name (First, Middle, Last) Frederick Michael Frank, Sr.	18. Mother's Name (First, Middle, Maiden Surname) Margaret McDonald
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19a. Informant's Name/Relationship (Type, Print) Nancy J. Frank -wife	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3205 Kilkenny Street Silver Spring, Maryland 20904
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20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery	Date 2/27/2012	20c. Location - City or Town, State Silver Spring, Maryland
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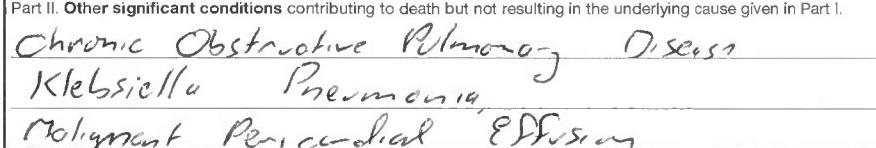
21. Signature of Funeral Service Licensee 	3. Name and Address of Facility Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705
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Physician/
Medical
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	Approximate Interval Between Onset and Death 3 years
a. Due to (or as a consequence of): 	
b. Due to (or as a consequence of):	
c. Due to (or as a consequence of):	
d. Due to (or as a consequence of):	

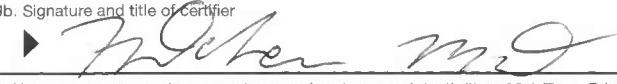
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 	23e. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No

25. Was or referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA	26. Place of Death (Check only one) Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)
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27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined	28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
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29b. Signature and title of certifier 	29c. License number D46120	29d. Date signed (Month, Day, Year) February 21, 2012
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Fernando DeLeon 10710 Charter Dr. Columbia, MD 21044
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31. Date filed (Month, Day, Year) FEB 24 2012	32. Registrar's Signature 
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Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial transit B

10+1
State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07564

1 - For State Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Doris Charlotte Jackson Frederick				2. Date of Death Month March Day 2 Year 2012	3. Time of Death 0118 AM			
	4a. Facility Name (if not institution, give street and number) 7065 Augustine Herman Highway		4b. City, Town, or Location of Death Earleville		4c. County of Death Cecil				
Funeral Director	5. Social Security Number 216-20-1016		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F 7. Age (in yrs. last birthday) 84 Yrs.		If Under 1 Year Months 0 Days 0 Hours 0 Min. 0	8. Date of Birth (Month, Day, Year) June 21, 1927	9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent Maryland		10a. State Maryland		10b. County Cecil		10c. City, Town or Location Elkton		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
To Be Completed by Funeral Director	10e. Street and Number 226 West High Street			10f. Zip Code 21921		10g. Citizen of What Country? United States			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. White	
Physician/ Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) 10			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Motor Repair		16b. Kind of Business Industry Electrical Motor Manufacturing			
	17. Father's Name (First, Middle, Last) William D. Jackson			18. Mother's Name (First, Middle, Maiden Surname) Hannah E. Hoover					
19a. Informant's Name/Relationship (Type, Print) Kim Frederick/Daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Post Office Box 233, Earleville, MD 21919						
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) R. A. Ferris & Co., Inc.		Date March 3, 2012	20c. Location - City or Town, State West Chester, PA			
21. Signature of Funeral Service Licensee Jones S. Hicks			22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, MD 21921						
Physician/ Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Coronary Artery Disease							Approximate Interval Between Onset and Death	
	b. Due to (or as a consequence of): Aneurysm Ascending Aorta								
Medical Certificate: To Be Completed by Physician/Medical Examiner	c. Due to (or as a consequence of): 								
	d. Due to (or as a consequence of): 								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown					23d. Date of delivery Month 0 Day 0 Year 0		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION Hypothyroidism Non Insulin Dependant Diabetes Mellitus							23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify)		23f. Daughter's Residence		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year) 5 <input type="checkbox"/> Pending Investigation		28b. Time of injury M		28c. Injury at work? 6 <input type="checkbox"/> Could not be determined 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier T. J. Scammell				29c. License number 133510				29d. Date signed (Month, Day, Year) MARCH 2 2012	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Timothy O'Donnell, M.D., Suite 32, Peoples Plaza, Newark, DE 19702									
31. Date filed (Month, Day, Year) MAR 12 2012		32. Registrar's Signature Karen S. Park							

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68700

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

**State
Registrar**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07565

1- For
State
Registrar

Physician/
Medical
Examiner

Baltimore, Maryland 21215-0036
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

State
Registrar

Funeral
Director

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. Decedent's Name (First, Middle, Last) David Shelton Fletcher				2. Date of Death Month February Day 20 , Year 2012	3. Time of Death 1625 M		
4a. Facility Name (if not institution, give street and number) 4102 Nottaway Place				4b. City, Town, or Location of Death Bowie			
4c. County of Death Prince George's		4d. County of Birth Prince George's					
5. Social Security Number 215-38-7388		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 69 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) May 16, 1942	9. Birthplace (State or Foreign Country) DC
10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Bowie			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number 4102 Nottaway Place				10f. Zip Code 20716			10g. Citizen of What Country? United States
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Black Specify:
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)		16b. Kind of Business Industry Public Works			16c. Kind of Business Industry Government
17. Father's Name (First, Middle, Last) James C. Fletcher				18. Mother's Name (First, Middle, Maiden Surname) Marguerite H. Shelton			
19a. Informant's Name/Relationship (Type, Print) Rosalind Fletcher - Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7908 Oxon Hill Road Oxon Hill, Maryland 20745			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, cemetery or other place) Maryland Veterans Cemetery		Date March 1, 2012	20c. Location - City or Town, State Cheltenham, Maryland		
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road NE Washington, DC 20019					

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death				
<p style="text-align: center;">Lung Cancer</p> <p>a. Due to (or as a consequence of):</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy, 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 6 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital:		26. Place of Death (Check only one) 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number D23743		29d. Date signed (Month, Day, Year) February 24, 2012				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Martin D. Weltz 7525 Greenway Center Drive Suite 205 Greenbelt, Md. 20770								
31. Date filed (Month, Day, Year) FEB 27 2012		32. Registrar's Signature 						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. **2012 07565**

1 For
State
Registrar

**Physician/
Medical
Examiner**

**Funeral
Director**

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 25a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Division of Vital Records, P.O. Box 68760

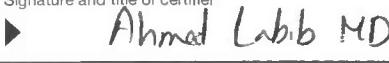
To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and
completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Physician/
Medical
Examiner**

Medical Certificate: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) William Coleman Guthrie			2. Date of Death Month February Day 25 Year 2012	3. Time of Death 8:25 a M
4a. Facility Name (if not institution, give street and number) Dorchester General Hospital			4b. City, Town, or Location of Death Cambridge	4c. County of Death Dorchester
5. Social Security Number 226-32-6885	6. Sex M	7. Age (In yrs. last birthday) Yrs. 83	If Under 1 Year Months 0 Days 0 Hours 0 Min. 0	8. Date of Birth (Month, Day, Year) Feb. 11, 1929
Usual Residence of Decedent 10a. State MD 10b. County Dorchester			10c. City, Town or Location Cambridge	
10e. Street and Number 102 Markley Court			10f. Zip Code 21613	10g. Citizen of What Country? USA
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates 1946-49		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: white	
15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) aerospace engineer		16b. Kind of Business Industry satellite systems
17. Father's Name (First, Middle, Last) Forest Guthrie, Jr.			18. Mother's Name (First, Middle, Maiden Surname) Edna Oslin	
19a. Informant's Name/Relationship (Type, Print) Gertrude T. Guthrie wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 102 Markley Court, Cambridge, MD 21613	
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Crematory of Delmarva		Date 2/27/12
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 21613		

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			Approximate Interval Between Onset and Death
<p>a. Due to (or as a consequence of): Heart Block</p> <p>b. Due to (or as a consequence of): Delirium Tremens</p> <p>c. Due to (or as a consequence of):</p> <p>d. _____</p>			
IF FEMALE:	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown		
23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide	28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28d. Describe how injury occurred
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			28f. Location (Street and Number or Rural Route Number, City or Town, State)
29b. Signature and title of certifier 	29c. License number D65528	29d. Date signed (Month, Day, Year) 02/25/2012	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ahmed Labib MD 300 Byron St., Cambridge MD 21613			
31. Date filed (Month, Day, Year) FEB 28 2012	32. Registrar's Signature 		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07567

1 - For
State
RegistrarPhysician/
Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

5

State
Registrar

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death			
<i>Glen Richard Goodwin</i>		2 23 2012		5:05 PM			
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death			
<i>17694 Maryland Highway</i>		<i>Swanton</i>		<i>Garrett</i>			
5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	8. Date of Birth (Month, Day, Year)		9. Birthplace (State or Foreign Country)	
<i>213-44-1408</i>		<input checked="" type="checkbox"/> M <input type="checkbox"/> F	<i>63</i>	Yrs.	If Under 1 Year Months Days Hours Min.	<i>May 28, 1948</i>	<i>Maryland</i>
Usual Residence of Decedent						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10a. State <i>MD</i>		10b. County <i>Garrett</i>		10c. City, Town or Location <i>Swanton</i>			
10e. Street and Number <i>17694 Maryland Highway</i>				10f. Zip Code <i>21561</i>		10g. Citizen of What Country? <i>United States</i>	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>white</i>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <i>Custodian</i>		16b. Kind of Business/Industry <i>Paper Manufacturer</i>			
17. Father's Name (First, Middle, Last) <i>Albert Goodwin</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>Anetia Virts</i>					
19a. Informant's Name/Relationship (Type, Print) <i>Wanda Goodwin/ wife</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>17694 Maryland Highway, Swanton, Maryland 21561</i>					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) <i>Virts Cemetery</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Virts Cemetery</i>		Date <i>02/26/2012</i>	20c. Location - City or Town, State <i>Swanton, Maryland</i>		
21. Signature of Funeral Service Licensee <i>F. Wayne Boal</i>		22. Name and Address of Facility <i>Boal Funeral Home 111 Church St, Westernport, Maryland 21562</i>					
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		a. Due to (or as a consequence of): <i>Eophageal Cancer with Mets</i>		Approximate Interval Between Onset and Death <i>8 months</i>			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. Due to (or as a consequence of):					
c. Due to (or as a consequence of):		d. Due to (or as a consequence of):					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) <i>Unknown</i>		23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) <i>Residence</i>					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Ronald Lee DO</i>		29c. License number <i>H2610-48</i>		29d. Date signed (Month, Day, Year) <i>2/23/2012</i>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>PT Daniel Miller DO 69 W 1/4 Acres Dr Oakland MD 21508</i>		31. Date filed (Month, Day, Year) <i>FEB 27 2012</i>		32. Registrar's Signature <i>Leigh S. Parker</i>			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07568

1 - For
State
RegisterPhysician/
Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Sandra Krehbiel Gardner

2. Date of Death

Month Day Year

3. Time of Death

12:50 A M

4a. Facility Name (if not institution, give street and number)
16349 Harwood Rd.4b. City, Town, or Location of Death
Frostburg4c. County of Death
AlleganyFuneral
Director

5. Social Security Number

143-34-4132

Usual Residence of Decedent

6. Sex

1 M 2 F

7. Age (In yrs. last birthday)

70 Yrs.

If Under 1 Year

Months Days Hours Min.

8. Date of Birth

(Month, Day, Year)

Nov. 12, 1941

9. Birthplace (State or Foreign Country)

New Jersey

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036
 permit. Page 1 and 2 should be filled within 72 hours after death with the Maryland
 Department of Health and Mental Hygiene.
 Important: If Item 27 is marked other than "natural", or items 28a or 28a-f show
 any injury or other traumatic event, the Medical Examiner must be notified at
 once.

10a. State

MD

10b. County

Allegany

10c. City, Town or Location

Frostburg

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

16349 Harwood Dr.

10f. Zip Code

21532

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12) College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

4 School Teacher

16b. Kind of Business/Industry

Elementary

17. Father's Name (First, Middle, Last)

Nathaniel William Krehbiel

18. Mother's Name (First, Middle, Maiden Surname)

Ellen Helle

19a. Informant's Name/Relationship (Type, Print)

Robert H. Gardner/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

16349 Harwood Dr., Frostburg, MD 21532

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Frostburg Mem. Park Feb. 28, 2012 Frostburg, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Newman Funeral Homes, P.A.
P.O. Box 275, Grantsville, MD 21536

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No
9 Unknown23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify)
9 Unknown23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

Other:

4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural
2 Accident
3 Suicide
4 Homicide5 Pending Investigation
6 Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work?

M 1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

2/27/12

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Huma Shakil, 625 Kent Ave., Cumberland, MD 21502

31. Date filed (Month, Day, Year)

FEB 28 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07569

1 - For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Raymond Eugene Geisler					2. Date of Death Month March Day 3 Year 2012	3. Time of Death 1:36 PM M				
	4a. Facility Name (if not institution, give street and number) 4709 Araby Church Road			4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick					
Funeral Director	5. Social Security Number 219-34-5259		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 73 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) Nov. 6, 1938	9. Birthplace (State or Foreign Country) Maryland			
	Usual Residence of Decedent		10a. State Maryland		10b. County Frederick		10c. City, Town or Location Frederick		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number 4709 Araby Church Road			10f. Zip Code 21704			10g. Citizen of What Country? U.S.A.				
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates. 1963-1963		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Electronics Supervisor			16b. Kind of Business/Industry Public School				
	17. Father's Name (First, Middle, Last) Glenn Vernon Geisler					18. Mother's Name (First, Middle, Maiden Surname) Edna Helen McDonough					
	19a. Informant's Name/Relationship (Type, Print) Allen R. Geisler, son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3452 Emys Place, Monrovia, MD 21770							
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Resthaven Mem. Gardens Mar. 8, 2012			20b. Place of Disposition (Name of cemetery, crematory or other place) Resthaven Mem. Gardens Mar. 8, 2012		Date	20c. Location - City or Town, State Frederick, MD				
	21. Signature of Funeral Service Licensee R.E. J.P.			22. Name and Address of Facility Keeney and Basford PA Funeral Home 106 East Church St., Frederick, MD 21701							
Physician/ Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) COPD Approximate Interval Between Onset and Death 5 years										
	b. Due to (or as a consequence of): Chronic Anemia Approximate Interval Between Onset and Death 5 years										
	c. Due to (or as a consequence of): Peripheral Vascular Disease Approximate Interval Between Onset and Death 5 years										
	d.										
Medical Certificate: To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred					
									28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								29c. License number D 46248		29d. Date signed (Month, Day, Year) 3/5/12
	29b. Signature and title of certifier Martha J. Pierce, M.D.										
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Martha J. Pierce, M.D., 300 West Ninth Street, Frederick, MD 21701										
State Registrar	31. Date filed (Month, Day, Year) MAR 12 2012		32. Registrar's Signature Debra J. Gandy								

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit.

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Raymond Eugene Geisler					2. Date of Death Month March Day 3 Year 2012	3. Time of Death 1:36 PM M				
	4a. Facility Name (if not institution, give street and number) 4709 Araby Church Road			4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick					
Funeral Director	5. Social Security Number 219-34-5259		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 73 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) Nov. 6, 1938	9. Birthplace (State or Foreign Country) Maryland			
	Usual Residence of Decedent		10a. State Maryland		10b. County Frederick		10c. City, Town or Location Frederick		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number 4709 Araby Church Road			10f. Zip Code 21704			10g. Citizen of What Country? U.S.A.				
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates. 1963-1963		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Electronics Supervisor			16b. Kind of Business/Industry Public School				
	17. Father's Name (First, Middle, Last) Glenn Vernon Geisler					18. Mother's Name (First, Middle, Maiden Surname) Edna Helen McDonough					
	19a. Informant's Name/Relationship (Type, Print) Allen R. Geisler, son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3452 Emys Place, Monrovia, MD 21770							
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Resthaven Mem. Gardens Mar. 8, 2012			20b. Place of Disposition (Name of cemetery, crematory or other place) Resthaven Mem. Gardens Mar. 8, 2012		Date	20c. Location - City or Town, State Frederick, MD				
	21. Signature of Funeral Service Licensee R.E. J.P.			22. Name and Address of Facility Keeney and Basford PA Funeral Home 106 East Church St., Frederick, MD 21701							
Physician/ Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) COPD Approximate Interval Between Onset and Death 5 years										
	b. Due to (or as a consequence of): Chronic Anemia Approximate Interval Between Onset and Death 5 years										
	c. Due to (or as a consequence of): Peripheral Vascular Disease Approximate Interval Between Onset and Death 5 years										
	d.										
Medical Certificate: To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred					
									28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								29c. License number D 46248		29d. Date signed (Month, Day, Year) 3/5/12
	29b. Signature and title of certifier Martha J. Pierce, M.D.										
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Martha J. Pierce, M.D., 300 West Ninth Street, Frederick, MD 21701										
State Registrar	31. Date filed (Month, Day, Year) MAR 12 2012		32. Registrar's Signature Debra J. Gandy								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07570

1 - For
State
Register

Physician/
Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/
Medical
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

1. Decedent's Name (First, Middle, Last) BERRY GILROY JR.				2. Date of Death Month MARCH Day 3 Year 2012	3. Time of Death 8:00A M
4a. Facility Name (if not institution, give street and number) 8374 GILROY ROAD				4b. City, Town, or Location of Death NANJEMOY	
5. Social Security Number 220-62-6078 Usual Residence of Decedent				6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 58 Yrs.
8. If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		9. Date of Birth (Month, Day, Year) JULY 13, 1953	
10a. State MD		10b. County CHARLES		10c. City, Town or Location NANJEMOY	
10e. Street and Number 8374 GILROY ROAD				10f. Zip Code 20662	
10g. Citizen of What Country? U. S. A.					
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) CARPENTER		16b. Kind of Business/Industry MITCHELL SUPPLY	
17. Father's Name (First, Middle, Last) JAMES BERRY GILROY				18. Mother's Name (First, Middle, Maiden Surname) JOSEPHINE MARGARET GILROY	
19a. Informant's Name/Relationship (Type, Print) MARY A. GILROY/SPOUSE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8374 GILROY ROAD NANJEMOY, MD 20662	
20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) GILROY FAMILY CEM	20c. Date of Disposition MARCH 9, 2012
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. 5635 WASHINGTON AVE., LA PLATA, MD 20646	
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) cancer of lung.					
Approximate Interval Between Onset and Death					
23b. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) cancer of lung.					
23c. If female: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown					
23d. Date of delivery Month Day Year					
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide					
28a. Date of injury (Month, Day, Year) 28b. Time of injury M 28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier 					
29c. License number D28352					
29d. Date signed (Month, Day, Year) 3-5-12					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Po Box 1703 6Place My 20646					
31. Date filed (Month, Day, Year) MAR 12 2012					
32. Registrar's Signature 					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2012 0757

Certificate of Death

Reg. No.

1- For
State
Registrar

Physician/
Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

1. Decedent's Name (First, Middle, Last) ROBERT CHRISTIAN GRUBER		2. Date of Death Month MARCH Day 4 , Year 2012		3. Time of Death 2:15A M
4a. Facility Name (if not institution, give street and number) SOUTHERN MD. HOSP. CENTER		4b. City, Town, or Location of Death CLINTON		4c. County of Death PRINCE GEORGES
5. Social Security Number 211-24-7520		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 78 Yrs.	If Under 1 Year Months Days Hours Min.
8. Usual Residence of Decedent MD. CHARLES		9. Birthplace (State or Foreign Country) PA.		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10a. State MD.		10b. County CHARLES		10c. City, Town or Location BRYANTOWN
10e. Street and Number 13500 FOX DEN PLACE		10f. Zip Code 20617		10g. Citizen of What Country? U.S.A.
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No ARMY If Yes, Give Year or Date RET.LT.COL.		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 5+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) RET.LT.COL.U.S.ARMY
16b. Kind of Business/Industry U.S.GOV'T.		17. Father's Name (First, Middle, Last) HARRY M. GRUBER		18. Mother's Name (First, Middle, Maiden Surname) ALMEDA GINGRICH
19a. Informant's Name/Relationship (Type, Print) EILEEN GRUBER-SPOUSE		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O.BOX 447 BRYANTOWN, MD. 20617		
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) METROPOLITAN CREMATORIAL 3-6-12		Date
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646		20c. Location - City or Town, State ALEX., VA.
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death)		LIPOSARCOMA Approximate Interval Between Onset and Death 272 years		
23b. Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last		a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number D18545		29d. Date signed (Month, Day, Year) MARCH 4, 2012
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) R. WISCONSIN, A. 12070 OCS LINE CENTER CLARKE MD 20602		31. Date filed (Month, Day, Year) MAR 12 2012		32. Registrar's Signature 

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07572

1 - For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last)							2. Date of Death Month <input type="text"/> Day <input type="text"/> Year <input type="text"/>	3. Time of Death 2245 PM
	Henry Edward Gibson Jr.							Bethesda	
Funeral Director	4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death			4c. County of Death		
	Suburban Hospital			Bethesda			Montgomery		
To Be Completed by Funeral Director	5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. <input type="text"/> 82		If Under 1 Year Months <input type="text"/> Days <input type="text"/> Hours <input type="text"/> Min. <input type="text"/>	8. Date of Birth (Month, Day, Year) <input type="text"/> Sept. 13, 1929		9. Birthplace (State or Foreign Country) Virginia
	228-28-4294 Usual Residence of Decedent								
10a. State DC	10b. County	10c. City, Town or Location Washington							10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number 1413 Belmont Street NW # 205				10f. Zip Code 20009				10g. Citizen of What Country? United States	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify African American
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)			16b. Kind of Business/Industry Mail Clerk			Private
17. Father's Name (First, Middle, Last) Henry Edward Gibson					18. Mother's Name (First, Middle, Maiden Surname) Josephine Martin				
19a. Informant's Name/Relationship (Type, Print) Doris M. Gibson - Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2120 16th Street NW #712 Washington, DC 20009					
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Lee's Crematory			Date <input type="text"/> March 3, 2012	20c. Location - City or Town, State Clinton, Maryland	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road NE Washington, DC 20019					
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PNEUMONIA									
Approximate Interval Between Onset and Death									
<p>a. Due to (or as a consequence of):</p> <p>{</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) _____ 9 <input type="checkbox"/> Unknown						23d. Date of delivery Month <input type="text"/> Day <input type="text"/> Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier 		29c. License number D0057124				29d. Date signed (Month, Day, Year) 2/22/12			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mustapha M. Mallah 9311C Willow Creek Drive Gaithersburg, Md. 20886									
31. Date filed (Month, Day, Year) FEB 27 2012		32. Registrar's Signature 							

2/21/12 2245 PM
Baltimore, Maryland 21215-0036

Gibson Henry
Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07573

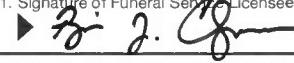
1 - For
State
Registrar

Physician/
Medical
Examiner

Funeral
Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

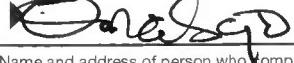
1. Decedent's Name (First, Middle, Last)				2. Date of Death Month Day Year				3. Time of Death		
Vera G. Hood				FEBRUARY 16 2012				7:15 AM		
4a. Facility Name (if not institution, give street and number)				4b. City, Town, or Location of Death				4c. County of Death		
BALTIMORE WASHINGTON MEDICAL CENTER				GLEN BURNIE				ANNE ARUNDEL		
5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month Day Year)		9. Birthplace (State or Foreign Country)		
218-32-7350		1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F	77 Yrs.	Months	Days	Hours	Min.	3/3/1934 MD		
Usual Residence of Decedent		10a. State		10b. County		10c. City, Town or Location				
		MD		Anne Arundel		Severn				
10e. Street and Number		10f. Zip Code				10g. Citizen of What Country?				
1353 Raleigh DR.		21144				USA				
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced										
15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business/Industry					
Elementary/Secondary (0-12) 12		College (1-4 or 5+) Secretary						Concrete		
17. Father's Name (First, Middle, Last)					18. Mother's Name (First, Middle, Maiden Surname)					
Marvin Slater					Helen Hood					
19a. Informant's Name/Relationship (Type, Print)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)						
Cheryl Wett Daughter				889R Claffy Ave. Gambrills, MD 21054						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place)			Date		20c. Location - City or Town, State			
		Epiphany Cemetery			2/20/2012		Odenton, MD			
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility			Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23c. Date of delivery Month Day Year	
<p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> <p>{</p> <p>a. Due to (or as a consequence of): PULMONARY EMBOLISM</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown		23d. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		23e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	
		28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29b. Signature and title of certifier  MD		29c. License number D 45149		29d. Date signed (Month, Day, Year) February 16 2012	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		31. Date filed (Month, Day, Year) FEB 21 2012		32. Registrar's Signature 	

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 20120154

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2012 07575

Reg. No.

1 - For
State
Registrar

Physician/
Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Samuel Hepperle
Baltimore, Maryland 21215-0036 DB/lets
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician/
Medical
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death M
Samuel William Hepperle, Sr.		February 19 2012		1228 M
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
Dorchester GENERAL HOSPITAL		CAMBRIDGE		Dorchester
5. Social Security Number 214-44-4907		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 66 Yrs.	8. Date of Birth (Month, Day, Year) Oct. 27, 1945
		If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	9. Birthplace (State or Foreign Country) Maryland
Usual Residence of Decedent		10a. State Maryland 10b. County Dorchester 10c. City, Town or Location Linkwood		
10e. Street and Number 3909 Manor Lane		10f. Zip Code 21835		10g. Citizen of What Country? USA
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Painter		16b. Kind of Business Industry Residential and Commercial
17. Father's Name (First, Middle, Last) William Dixon Hepperle, Sr.		18. Mother's Name (First, Middle, Maiden Surname) Emily Mae Hubley		
19a. Informant's Name/Relationship (Type, Print) Lucy E. Hepperle/Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P. O. Box 313, Linkwood, Maryland 21835		
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Crematory Of Delmarva		Date 2/21/2012
21. Signature of Funeral Service License 		22. Name and Address of Facility Zeller Funeral Home, P. O. Box 207 106 Main Street, East New Market, MD 21631		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death		
a. PROBABLE ASCVD Due to (or as a consequence of):				
b. Due to (or as a consequence of):				
c. Due to (or as a consequence of):				
d. Due to (or as a consequence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier  29c. License number DO068045 29d. Date signed (Month, Day, Year) FEBRUARY 19, 2012		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kavita Mohan, M.D., 609 Daffin Lane, Denton, Maryland 21629		31. Date filed (Month, Day, Year) FEB 28 2012 32. Registrar's Signature 		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2012 07576

Certificate of Death

Reg. No.

For
State
Registrar

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) Raymond Leroy Hohlbein						2. Date of Death Month February Day 26 Year 2012		3. Time of Death 12:00 a M	
		4a. Facility Name (if not institution, give street and number) Mallard Bay Care Center			4b. City, Town, or Location of Death Cambridge			4c. County of Death Dorchester			
Funeral Director		5. Social Security Number 216-24-0974		6. Sex 1 X M 2 □ F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) April 6, 1928	9. Birthplace (State or Foreign Country) Maryland		
		Usual Residence of Decedent									
To Be Completed by Funeral Director		10a. State MD		10b. County Dorchester		10c. City, Town or Location Cambridge			10d. Inside City Limits 1 X Yes 2 □ No		
		10e. Street and Number 208 Meteor Avenue Apt. 503		10f. Zip Code 21613			10g. Citizen of What Country? USA				
		11. Marital Status 1 □ Never Married 2 X Married 3 □ Widowed 4 □ Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates. WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 X No Specify: white			14. Race - American Indian, Black, White, etc. Specify: white		
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) welder		16b. Kind of Business/Industry engine repair					
		17. Father's Name (First, Middle, Last) John Hohlbein				18. Mother's Name (First, Middle, Maiden Surname) Ruth Myers					
		19a. Informant's Name/Relationship (Type, Print) Madeline Joy Hohlbein wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 208 Meteor Avenue Apt. 503, Cambridge, MD 21613							
		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Cem		Date 3/2/12		20c. Location - City or Town, State Hurlock, MD			
		21. Signature of Funeral Service Licensee B.K.R.		22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 21613							
Physician/ Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) chronic obstructive pulmonary disease								Approximate Interval Between Onset and Death 10 years	
		b. Due to (or as a consequence of): pneumonia								Approximate Interval Between Onset and Death 3 months	
		c. Due to (or as a consequence of):									
		d. Due to (or as a consequence of):									
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 X No 9 □ Unknown		23c. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (Specify) 9 □ Unknown						23d. Date of delivery Month Day Year	
Medical Certificate To Be Completed by Physician/Medical Examiner		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. diabetes, hypertension								23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 □ Probably 4 □ Unknown	
										24a. Was an autopsy performed? 1 □ Yes 2 X No	
										24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No	
		25. Was case referred to medical examiner? 1 □ Yes 2 X No		Hospital:		26. Place of Death (Check only one) 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA 4 X Nursing Home 5 □ Residence 6 □ Other (Specify)					
		27. Manner of Death 1 X Natural 5 □ Pending Investigation 2 □ Accident 6 □ Could not be determined 3 □ Suicide 4 □ Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at work? 1 □ Yes 2 □ No		28d. Describe how injury occurred	
										28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
		29a. Certifier (Check only one) 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 □ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number 10059973						29d. Date signed (Month, Day, Year) 2/28/12	
		29b. Signature and title of certifier Patricia Johnson									
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Patricia Johnson 100 Bramble Cambridge MD									
State Registrar		31. Date filed (Month, Day, Year) FEB 28 2012		32. Registrar's Signature Jeanne J. Parker							

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

LJH
Baltimore, Maryland 21215-0036
permit Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

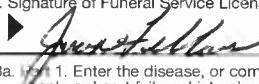
2012 07577

1- For
State
RegistrarPhysician/
Medical
ExaminerFuneral
Director

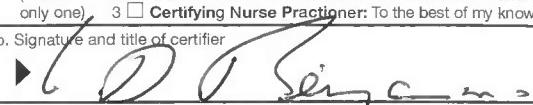
Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) CAROL JOSEPHINE HESSEY			2. Date of Death Month FEBRUARY Day 14 , Year 2012	3. Time of Death 1:40 P.M.
4a. Facility Name (if not institution, give street and number) CHESTER RIVER MANOR			4b. City, Town, or Location of Death CHESTERTOWN	
5. Social Security Number 279-30-7768			6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 77
			If Under 1 Year Months	If Under 24 Hrs. Hours Min.
			8. Date of Birth (Month, Day, Year) 12/07/1934	9. Birthplace (State or Foreign Country) OHIO
10a. State MD			10b. County KENT	
10c. City, Town or Location CHESTERTOWN			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 8967 ORCHARD DRIVE			10f. Zip Code 21620	10g. Citizen of What Country? UNITED STATES
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+		16b. Kind of Business Industry TEACHER EDUCATION
17. Father's Name (First, Middle, Last) ROY SMITH			18. Mother's Name (First, Middle, Maiden Surname) JOSEPHINE BIGELOW	
19a. Informant's Name/Relationship (Type, Print) JUDY COLEMAN / DAUGHTER			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10448 WORTON ROAD WORTON, MARYLAND 21678	
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) CHESAPEAKE CREMATION		Date 02/16/2012
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 130 SPEER ROAD CHESTERTOWN, MARYLAND 21620		

Medical Certificate: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Due to (or as a consequence of): Mesothelioma		Approximate Interval Between Onset and Death 3 months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. Due to (or as a consequence of):	b. Due to (or as a consequence of):	c. Due to (or as a consequence of):
		d. Due to (or as a consequence of):		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28d. Describe how injury occurred 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number D16483		
29b. Signature and title of certifier 		29d. Date signed (Month, Day, Year) 2/15/12		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wayne D. Benjamin, M.D., Chestertown, MD 21620				
31. Date filed (Month, Day, Year) FEB 17 2012		32. Registrar's Signature 		

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07578

1 - For State Registrar

Physician/
Medical
Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Physician/
Medical
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. Decedent's Name (First, Middle, Last) TIMOTHY HUSKEY SR.		2. Date of Death Month February Day 14 , Year 2012		3. Time of Death 8:06 M
4a. Facility Name (if not institution, give street and number) 1996 Addison Road		4b. City, Town, or Location of Death District Heights		4c. County of Death Prince George's
5. Social Security Number 579-92-8028		6. Sex M	7. Age (In yrs. last birthday) 49 Yrs.	If Under 1 Year Months Days Hours Min.
8. Date of Birth (Month, Day, Year) 01-06-1963		9. Birthplace (State or Foreign Country) DC		10d. Inside City Limits Yes Yes No No
10a. State MD		10b. County PG	10c. City, Town or Location DISTRICT HEIGHTS	
10e. Street and Number 1996 ADDISON ROAD SOUTH		10f. Zip Code 20747		10g. Citizen of What Country? US
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates. 12		13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: BLACK
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) TRUCK DRIVER		16b. Kind of Business/Industry PRIVATE
17. Father's Name (First, Middle, Last) THOMAS E. HUSKEY		18. Mother's Name (First, Middle, Maiden Surname) SHIRLEY J. MOON		
19a. Informant's Name/Relationship (Type, Print) KINYA HUSKEY/SISTER		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5446 85TH AVENUE, APART. # 101, NEW CARROLLTON, MARYLAND 20784		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) ► BURIAL		20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans		Date 3-06-2012 20c. Location - City or Town, State Cheltenham, MD
21. Signature of Funeral Service Licensee ► BETH G. DUNGEY MCLOPS		22. Name and Address of Facility POPE FUNERAL HOMES, P.A. 5538 MARLBORO PIKE, FORESTVILLE, MD 20747		
23a. Part I: Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Due to (or as a consequence of): Lewkevia		Approximate Interval Between Onset and Death
23c. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23d. Due to (or as a consequence of):		
23e. Due to (or as a consequence of):		23f. Due to (or as a consequence of):		
23g. Due to (or as a consequence of):		23h. Due to (or as a consequence of):		
23i. Due to (or as a consequence of):		23j. Due to (or as a consequence of):		
23k. Due to (or as a consequence of):		23l. Due to (or as a consequence of):		
23m. Due to (or as a consequence of):		23n. Due to (or as a consequence of):		
23o. Due to (or as a consequence of):		23p. Due to (or as a consequence of):		
23q. Due to (or as a consequence of):		23r. Due to (or as a consequence of):		
23s. Due to (or as a consequence of):		23t. Due to (or as a consequence of):		
23u. Due to (or as a consequence of):		23v. Due to (or as a consequence of):		
23w. Due to (or as a consequence of):		23x. Due to (or as a consequence of):		
23y. Due to (or as a consequence of):		23z. Due to (or as a consequence of):		
24a. IF FEMALE:		24b. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24c. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Scotter's home		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred
29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number H0055827		29d. Date signed (Month, Day, Year) February 14, 2012
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Salvador Sy/verte 3001 Hospital Drive, Severely, Maryland		31. Date filed (Month, Day, Year) MAR 12 2012		32. Registrar's Signature Leanne A. Farad

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07579

1- For
State
RegistrarPhysician/
Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

ETHEL JOHNSON
 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland
 Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 28a or 28a-f show
 any injury or other traumatic event, the Medical Examiner must be notified at
 once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed
 within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and
 completed filled in by the funeral director, page 2 should be detached for use as the burial-transit
 once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month <u>02</u> Day <u>28</u> Year <u>2012</u>		3. Time of Death <u>10:26AM</u>
<u>ETHOL E. JOHNSON</u>				
4a. Facility Name (if not institution, give street and number) <u>222 S SECOND ST</u>		4b. City, Town, or Location of Death <u>DENTON, MD</u>		4c. County of Death <u>CAROLINE</u>
5. Social Security Number <u>218-30-1133</u>		6. Sex <u>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F</u>	7. Age (In yrs. last birthday) <u>92 Yrs.</u>	If Under 1 Year Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>
				8. Date of Birth (Month, Day, Year) <u>June 5, 1919</u>
				9. Birthplace (State or Foreign Country) <u>Maryland</u>
Usual Residence of Decedent				
10a. State <u>Maryland</u>	10b. County <u>Caroline</u>	10c. City, Town or Location <u>Denton</u>		
10e. Street and Number <u>222 South Second Street</u>		10f. Zip Code <u>21629</u>		10g. Citizen of What Country? <u>USA</u>
11. Marital Status <u>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</u>		12. Was Decedent Ever in U.S. Armed Forces? <u>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</u> If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <u>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:</u>	14. Race - American Indian, Black, White, etc. <u>White</u>
15. Decedent's Education (Specify only highest grade completed) <u>Elementary/Secondary (0-12) 11 H.S. Grad.</u>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>College (1-4 or 5+) Office Manager</u>	16b. Kind of Business Industry <u>Agriculture</u>	
17. Father's Name (First, Middle, Last) <u>Everett Aldridge Pepper, Sr.</u>			18. Mother's Name (First, Middle, Maiden Surname) <u>Daisy Munck</u>	
19a. Informant's Name/Relationship (Type, Print) <u>Robert Pepper/nephew</u>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>4185 S. Jimmy Drive Rocky Face, GA 30740</u>		
20a. Method of Disposition <u>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State</u> 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) <u>Ronald Johnson</u>		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Denton Cemetery</u>	Date <u>3/3/2012</u>	20c. Location - City or Town, State <u>Denton, Maryland</u>
21. Signature of Funeral Service Licensee		22. Name and Address of Facility <u>Moore Funeral Home, P.A.</u> <u>12 South Second Street Denton, Maryland 21629</u>		
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <u>PNEUMONIA</u>				
Approximate Interval Between Onset and Death				
<p>a. Due to (or as a consequence of): <u>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</u></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <u>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown</u>		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown		
		23d. Date of delivery Month <u></u> Day <u></u> Year <u></u>		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				
25. Was case referred to medical examiner? <u>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</u>		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death <u>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation</u> 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. Signature and title of certifier <u>Jane R. Long</u>		29c. License number <u>D00575-09</u>		29d. Date signed (Month, Day, Year) <u>02/28/2012</u>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>ETHOL E. JOHNSON 609 Daffin Ln Denton, MD 21629</u>				
31. Date filed (Month, Day, Year) <u>MAR 08 2012</u>		32. Registrar's Signature <u>Jane R. Long</u>		

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

2012 07580

Reg. No.

1- For
State
Registrar**Physician/
Medical
Examiner**

1. Decedent's Name (First, Middle, Last) Loetta R. Johnson				2. Date of Death Month Day Year February 21 2012				3. Time of Death 9:20 PM	
4a. Facility Name (if not institution, give street and number) Shady Grove Adventist Hospital				4b. City, Town, or Location of Death Rockville				4c. County of Death Montgomery	
5. Social Security Number 506-28-7794		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) Aug. 30, 1926	9. Birthplace (State or Foreign Country) Nebraska		
Usual Residence of Decedent MD Montgomery		10a. State MD		10b. County Montgomery		10c. City, Town or Location Gaithersburg		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 7704 Warfield Road				10f. Zip Code 20882				10g. Citizen of What Country? United States	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates. 12		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Office Manager			16b. Kind of Business/Industry Moving & Storage			
17. Father's Name (First, Middle, Last) George Schoenholz				18. Mother's Name (First, Middle, Maiden Surname) Rosa Eppler					
19a. Informant's Name/Relationship (Type, Print) Barbara Johnson (Daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 703 Van Buren Street, N W , Washington DC 20012					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Terry A. Fawcett			20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery		Date February 25, 2012	20c. Location - City or Town, State Silver Spring, MD			
21. Signature of Funeral Service Licensee M01117			22. Name and Address of Facility DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg, MD 20878						

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23c. Approximate Interval Between Onset and Death	
<p>a. Cardiac arrhythmia Due to (or as a consequence of):</p> <p>b. Septic shock Due to (or as a consequence of):</p> <p>c. Severe sepsis Due to (or as a consequence of):</p> <p>d. _____</p>					

IF FEMALE:		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. acute renal failure				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
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25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide	
		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	

29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Mehari			
--	--	--	--	--	--

29c. License number D0064478		29d. Date signed (Month, Day, Year) February 22, 2012			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Fisehatson Mehari MD 9901 Medical Center Rockville, MD 20850					

31. Date filed (Month, Day, Year) FEB 24 2012		32. Registrar's Signature Jeanne J. Gates			
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Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial permit.

Medical Certificate: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 20b per FH G925 3/14/12 dk

State of Maryland / Department of Health and Mental Hygiene

2012 07581

Certificate of Death

Reg. No.

1 - For State Registrar

Physician/
Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

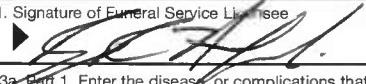
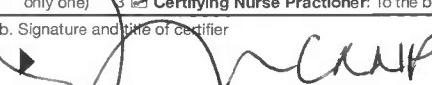
Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month <u>2</u> Day <u>16</u> Year <u>12</u>		3. Time of Death <u>0300am</u>
<u>Okey Joshua</u>				
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
<u>Spa Creek Center</u>		<u>Annapolis</u>		<u>Anne Arundel</u>
5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <u>60</u> Yrs.	8. Date of Birth (Month, Day, Year) <u>9/5/1951</u>
			If Under 1 Year Months <u></u> Days <u></u>	If Under 24 Hrs. Hours <u></u> Min. <u></u>
9. Birthplace (State or Foreign Country) <u>MARYLAND</u>				
10a. State <u>MD</u>		10b. County <u>ANNE ARUNDEL</u>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number <u>35 MILKSHAKE LANE</u>		10f. Zip Code <u>21401</u>		10g. Citizen of What Country? <u>USA</u>
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates. <u>6</u>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <u></u>
15. Decedent's Education (Specify only highest grade completed) <u>Elementary/Seconday (0-12)</u>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>N/A</u>		16b. Kind of Business Industry <u>N/A</u>
17. Father's Name (First, Middle, Last) <u>GEORGE W. JOSHUA</u>		18. Mother's Name (First, Middle, Maiden Surname) <u>MARY JO HENDERSON</u>		
19a. Informant's Name/Relationship (Type, Print) <u>JANE LIBBY/GUARDIAN</u>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>601 BURTONS COVE WAY 2 ANNAPOLIS, MD 21401</u>		
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <u>CHESAPEAKE CREMATION CENTER</u>		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>CHESAPEAKE CREMATION CENTER</u>		Date <u>2/18/2012</u>
20c. Location - City or Town, State <u>STEVENSVILLE</u>				
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <u>LASTING TRIBUTES FELLOWS</u> <u>ELFENBEIN & NEWNAM CREMATION & FUNERAL CARE</u> <u>314 BESTGATE ROAD ANNAPOLIS, MD 21401</u>		
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <u>Pneumonia</u>		Approximate Interval Between Onset and Death		
a. Due to (or as a consequence of): <u>dysphagia</u>				
b. Due to (or as a consequence of): <u>Failure to thrive</u>				
c. Due to (or as a consequence of): <u></u>				
d. <u></u>				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
				28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input checked="" type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <u>R1351020</u>		
29b. Signature and title of certifier 		29d. Date signed (Month, Day, Year) <u>2/16/12</u>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Jennifer Frey 6934 Anacostia Blvd skb Glen Burnie MD</u>				
31. Date filed (Month, Day, Year) <u>FEB 21 2012</u>		32. Registrar's Signature <u>Anna S. Park</u>		

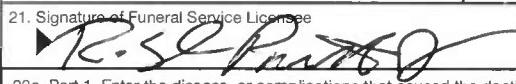
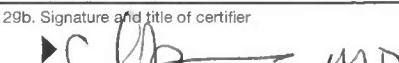
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07582

1 - For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Ernest L Jones</i>						2. Date of Death Month 2 Day 29 Year 2012	3. Time of Death 8:04 PM	
	4a. Facility Name (if not institution, give street and number) <i>University of Maryland Medical Center</i>			4b. City, Town, or Location of Death <i>Baltimore</i>			4c. County of Death PA		
Funeral Director	5. Social Security Number 220-52-5631	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 60 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) 09/01/1951	9. Birthplace (State or Foreign Country) PA		
To Be Completed by Funeral Director	10a. State MD		10b. County Carroll		10c. City, Town or Location Westminster			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 1935 Running Brooke Drive			10f. Zip Code 21158			10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) vice-president/owner			16b. Kind of Business/Industry racing promotions		
	17. Father's Name (First, Middle, Last) Ernest Jones, Sr				18. Mother's Name (First, Middle, Maiden Surname) Kathleen Stewart				
Physician/ Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Nancy Jones/wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1935 Running Brooke Drive, Westminster, MD 21158			20c. Location - City or Town, State Westminster, MD		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) St. Mary's Cemetery			20b. Place of Disposition (Name of cemetery, crematory or other place)			Date 03/04/2012		
Medical Certificate: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Pritts Funeral Home and Chapel, PA 412 Washington Road, Westminster, MD 21157					
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Intracranial hemorrhage</u> Due to (or as a consequence of): _____ b. <u>Mebritati lung cancer</u> Due to (or as a consequence of): _____ c. _____ Due to (or as a consequence of): _____ d. _____								
	Approximate Interval Between Onset and Death 2 days								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____								
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)								
	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
	29b. Signature and title of certifier  MD			29c. License number AV4176435B100SSZ			29d. Date signed (Month, Day, Year) 2/29/12		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Christopher Brown 22 S Greene St Suite S-12-D Baltimore, MD 21201								
State Registrar	31. Date filed (Month, Day, Year) MAR 12 2012		32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07583

1 - For
State
Registrar

Physician/
Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland
Department. If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death 1:00 P M
Jacqueline Denise Jones		February 19, 2012		
4a. Facility Name (if not institution, give street and number) 1906 Owens Road		4b. City, Town, or Location of Death Oxon Hill		4c. County of Death Prince George's
5. Social Security Number 578-78-5798		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 56 Yrs.	If Under 1 Year Months Days Hours Min.
Usual Residence of Decedent Maryland		10c. City, Town or Location Oxon Hill		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10a. State Maryland		10b. County Prince George's	10f. Zip Code 20745	10g. Citizen of What Country? United States
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Black
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Security Officer		16b. Kind of Business Industry Private
17. Father's Name (First, Middle, Last) Robert P. Woodland		18. Mother's Name (First, Middle, Maiden Surname) Gladys Queen		
19a. Informant's Name/Relationship (Type, Print) Russell Tolson - Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1906 Owens Road Oxon Hill, Maryland 20745		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Heritage		Date Feb. 27, 2012
20c. Location - City or Town, State Waldorf, Maryland				
21. Signature of Funeral Service Licensee John T. Stewart Jr.		22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road NE Washington, DC 20019		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death 3 month
a. Due to (or as a consequence of): T-lymphoblastic leukemia				
b. Due to (or as a consequence of):				
c. Due to (or as a consequence of):				
d. Due to (or as a consequence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No
		28d. Describe how injury occurred	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29d. Date signed (Month, Day, Year) 2/24/2012
29b. Signature and title of certifier Marie A. Perrin		29c. License number 052756		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Marie A. Perrin 445 Detour Hwy Annapolis MD 21401				
31. Date filed (Month, Day, Year) FEB 27 2012		32. Registrar's Signature Marie A. Perrin		

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07584

1- For
State
Registrar

Physician/
Medical
Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death	
Frances Marie Kearney		Month Feb. Day 19, Year 2012		12:30 AM	
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death	
490 N. Patuxent Road		Odenton		Anne Arundel	
5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.
219-48-0249		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	64 Yrs.	Months	Days
Usual Residence of Decedent				Hours	Min.
10a. State		10b. County	10c. City, Town or Location		
MD		Anne Arundel	Odenton		
10e. Street and Number		10f. Zip Code		10g. Citizen of What Country?	
490 N. Patuxent Road #47		21113		USA	
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)		14. Race - American Indian, Black, White, etc.
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		Specify: White
15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry	
Elementary/Secondary (0-12) 12		College (1-4 or 5+) Self Employed		Data Entry	
17. Father's Name (First, Middle, Last)			18. Mother's Name (First, Middle, Maiden Surname)		
Robert Richstatter			Willie Kee Hendren		
19a. Informant's Name/Relationship (Type, Print)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)		
Cynthia LeBlanc (daughter)			490 N. Patuxent Rd. Odenton, MD 21113		
20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date	20c. Location - City or Town, State
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) Atlantic Crematory				2/19/2012	Glen Burnie, MD
21. Signature of Funeral Service licensee		22. Name and Address of Facility Hardesty Funeral Home P.A. 851 Annapolis Rd Gambrills, MD 21054			
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.		Approximate Interval Between Onset and Death			
Immediate Cause (Final disease or condition resulting in death)		LUNG cancer 4 mos.			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
a. Due to (or as a consequence of):					
b. Due to (or as a consequence of):					
c. Due to (or as a consequence of):					
d. Due to (or as a consequence of):					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No g <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) daughter's house		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier ► J. Selonick, M.D.		29c. License number D19838		29d. Date signed (Month, Day, Year) 2/20/2012	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stuart E. Selonick, M.D. 2003 Medical Parkway, Annapolis, Md.					
31. Date filed (Month, Day, Year) FEB 21 2012		32. Registrar's Signature J. A. Pace			

Baltimore, Maryland 21215-0036

permits. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1- For State Registrar
**Physician/
Medical
Examiner**

**Funeral
Director**

To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07585

1. Decedent's Name (First, Middle, Last) Gladys V. Krum			2. Date of Death Month February Day 21 , Year 2012	3. Time of Death 4:12 A.M.	
4a. Facility Name (if not institution, give street and number) 14217 Chadwick Lane			4b. City, Town, or Location of Death Rockville		
4c. County of Death Montgomery					
5. Social Security Number 577-32-8974		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days Hours Min.	
8. Usual Residence of Decedent MD		9. Birthplace (State or Foreign Country) D.C.			
10a. State MD	10b. County Montgomery	10c. City, Town or Location Rockville			
10e. Street and Number 14217 Chadwick Lane			10f. Zip Code 20853	10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) secretary		16b. Kind of Business/Industry U.S. Government	
17. Father's Name (First, Middle, Last) Walter W. Coe			18. Mother's Name (First, Middle, Maiden Surname) Gladys M. Ort		
19a. Informant's Name/Relationship (Type, Print) Arthur Krum, III/son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9308 Oak Spring Ct., Frederick, MD 21701		
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Stauffer Crematory	Date 02/23/2012	20c. Location - City or Town, State Frederick, MD	
21. Signature of Funeral Service Licensee Ashley C. Myers		22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 21702			
23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)			Approximate Interval Between Onset and Death		
<p>a. RESPIRATORY FAILURE Due to (or as a consequence of):</p> <p>b. LUNG CANCER Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>			6 MONTHS		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number 035965			
29b. Signature and title of certifier David B. Harding, MD		29d. Date signed (Month, Day, Year) FEBRUARY 22, 2012			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David B. Harding, MD 1811 Prince Philip Dr. Chevy MD 20832		32. Registrar's Signature James A. Jones			
31. Date filed (Month, Day, Year) FEB 23 2012					

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07586

1- For State Registrar

Physician/
Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Kragh Helena M458856
Baltimore, Maryland 21215-0036

Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/
Medical
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

1- For State Registrar		State of Maryland / Department of Health and Mental Hygiene Certificate of Death										
		1. Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death				
		Helena Kragh				Month February Day 23 Year 2012		10:00 p m				
		4a. Facility Name (if not institution, give street and number)				4b. City, Town, or Location of Death						
		Civista Medical Center				La Plata						
		5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year		If Under 24 Hrs				
		218-16-2564		<input type="checkbox"/> M <input checked="" type="checkbox"/> F	91	Yrs.	Months	Days	Hours	Min.		
		Usual Residence of Decedent										
		10a. State	10b. County	10c. City, Town or Location								
		MD	Charles	Waldorf								
		10e. Street and Number				10f. Zip Code		10g. Citizen of What Country?				
		1753 Red Oak Lane				20601		United States				
		11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			14. Race - American Indian, Black, White, etc.			
		<input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			Specify: White			
		15. Decedent's Education (Specify only highest grade completed)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business/Industry			
		Elementary/Secondary (0-12) 12		College (1-4 or 5+) Naval Ordinance Station					Department of Defense			
		17. Father's Name (First, Middle, Last)				18. Mother's Name (First, Middle, Maiden Surname)						
		John P. Grabis				Barbara M. Therres						
		19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)								
		Mary Jo Cusick(Daughter)		1753 Red Oak Lane Waldorf, MD. 20601								
		20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date		20c. Location - City or Town, State				
		<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		MD. Veteran's Cemetery		3/5/2012		Cheltenham, Maryland				
		21. Signature of Funeral Service Licensee		22. Name and Address of Facility								
		Kellin Brem M0190		Hunt Funeral Home 3035 Old Washington Road Waldorf, MD. 20601								
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
		Immediate Cause (Final disease or condition resulting in death) ADVANCED ATHEROSCLEROSIS,										
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
		<p>a. Due to (or as a consequence of): DECOMPARESSED CONGESTIVE HEART FAILURE</p> <p>b. Due to (or as a consequence of): URINARY TRACT INFECTION.</p> <p>c. Due to (or as a consequence of):</p>										
		d.										
		IF FEMALE:		23c. If yes, outcome of pregnancy						23d. Date of delivery		
		23b. Was decedent pregnant in the past 12 months?		<input type="checkbox"/> Live Birth	<input type="checkbox"/> Fetal death	<input type="checkbox"/> Ectopic pregnancy				Month	Day	Year
		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		<input type="checkbox"/> Pregnant at time of death	<input type="checkbox"/> Other (specify)							
		23e. Did tobacco use contribute to the cause of death?										
		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
		24a. Was an autopsy performed?		24b. Were autopsy findings available prior to completion of cause of death?								
		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No								
		25. Was case referred to medical examiner?		26. Place of Death (Check only one)								
		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA				Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
		27. Manner of Death		28a. Date of injury (Month, Day, Year)		28b. Time of injury	28c. Injury at work?	28d. Describe how injury occurred				
		<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide				M	<input type="checkbox"/> Yes <input type="checkbox"/> No					
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
		29a. Certifier		29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
		<input checked="" type="checkbox"/> Physician <input type="checkbox"/> Medical Examiner <input type="checkbox"/> Nurse Practitioner										
		29b. Signature and title of certifier		29c. License number				29d. Date signed (Month, Day, Year)				
		Gwendolyn L. Lewis		D 20629				2/24/12				
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		Gwendolyn L. Lewis MD WALDORF, MD 20603								
		31. Date filed (Month, Day, Year)		32. Registrar's Signature								
		FEB 28 2012		Leanne S. Jones								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07587

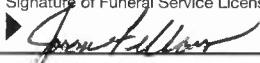
1 - For
State
RegistrarPhysician/
Medical
ExaminerFuneral
Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

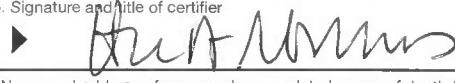
1. Decedent's Name (First, Middle, Last) ROBERT FREDERICK KITZ				2. Date of Death Month FEBRUARY Day 11 , Year 2012				3. Time of Death 2:13 A M	
4a. Facility Name (if not institution, give street and number) CHESTER RIVER HOSPITAL CENTER				4b. City, Town, or Location of Death CHESTERTOWN				4c. County of Death KENT	
5. Social Security Number 147-18-1719		6. Sex 1 X M 2 F	7. Age (in yrs. last birthday) 88 Yrs.	If Under 1 Year Months		If Under 24 Hrs. Hours		8. Date of Birth (Month, Day, Year) 01/31/1924	9. Birthplace (State or Foreign Country) PENNSYLVANIA
Usual Residence of Decedent MARYLAND		10a. State MARYLAND		10b. County KENT		10c. City, Town or Location ROCK HALL			
10e. Street and Number 4926 HUNTINGFIELD ROAD				10f. Zip Code 21661				10g. Citizen of What Country? UNITED STATES	
11. Marital Status 1 □ Never Married 2 X Married		12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates. 1943-45		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 X No Specify:				14. Race - American Indian, Black, White, etc. WHITE	
15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 4 INDUSTRIAL HYGENIST		16b. Kind of Business Industry OIL AND GAS					
17. Father's Name (First, Middle, Last) FREDERICK KITZ				18. Mother's Name (First, Middle, Maiden Surname) EMILY GOODMAN					
19a. Informant's Name/Relationship (Type, Print) JANE CHATTEN KITZ / WIFE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4926 HUNTINGFIELD ROAD ROCK HALL, MARYLAND 21661					
20a. Method of Disposition 1 □ Burial 2 X Cremation 3 □ Removal from State		20b. Place of Disposition (Name of cemetery, crematory or other place) CHESAPEAKE CREMATION		Date 02/13/2012		20c. Location - City or Town, State STEVENSVILLE, MARYLAND			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWMAN FUNERAL HOME, P.A. 130 SPEER ROAD CHESTERTOWN, MARYLAND 21620					

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Division of Vital Records, P.O. Box 68760

Medical Certificate: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23b. Due to (or as a consequence of): PARKINSONS DISEASE				Approximate Interval Between Onset and Death 5 years	
		23c. Due to (or as a consequence of): 23d. Date of delivery Month Day Year					
		23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 X No 3 □ Probably 4 □ Unknown					
23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		23c. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CONGESTIVE HEART FAILURE						23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 X No 3 □ Probably 4 □ Unknown	
25. Was case referred to medical examiner? 1 □ Yes 2 X No		26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)				24a. Was an autopsy performed? 1 □ Yes 2 X No	
27. Manner of Death 1 X Natural 5 □ Pending Investigation 2 □ Accident 6 □ Could not be determined		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? 1 □ Yes 2 □ No	28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 □ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						29d. Date signed (Month, Day, Year) 2-13-2012	
29b. Signature and title of certifier 		29c. License number D0041587					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Helen Nobel 122 Speer Road Chestertown, MD 21620						31. Date filed (Month, Day, Year) FEB 17 2012	
32. Registrar's Signature 							

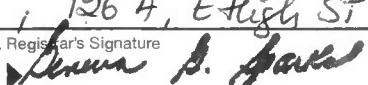
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07588

1 - For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Joan Lorraine King				2. Date of Death Month March Day 1 Year 2012	3. Time of Death 0350 AM	
	4a. Facility Name (if not institution, give street and number) Elkton Care and Rehabilitation Center		4b. City, Town, or Location of Death Elkton		4c. County of Death Cecil		
Funeral Director	5. Social Security Number 177-30-6863	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 74 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) FEB 12, 1938	9. Birthplace (State or Foreign Country) Pennsylvania	
	Usual Residence of Decedent 10a. State Maryland 10b. County Cecil		10c. City, Town or Location Elkton			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number 502 North Bridge Street			10f. Zip Code 21921	10g. Citizen of What Country? United States		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates. Elementary/Seconday (0-12) 12	13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White	14. Race - American Indian, Black, White, etc.			
	15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) 12	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerk	16b. Kind of Business Industry Retail				
	17. Father's Name (First, Middle, Last) Hibbard S. Evans	18. Mother's Name (First, Middle, Maiden Surname) Edith L. Oliver					
	19a. Informant's Name/Relationship (Type, Print) David H. King/Husband	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 502 North Bridge Street, Elkton, MD 21921					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) Cherry Hill Methodist Cemetery	Date March 6, 2012	20c. Location - City or Town, State Cherry Hill, MD			
	21. Signature of Funeral Service Licensee 	22. Name and Address of Facility Hicks Home for Funerals, P.A.	103 W. Stockton Street, Elkton, MD 21921				
Physician/ Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Glioblastoma					Approximate Interval Between Onset and Death Unknown	
	<p>a. Due to (or as a consequence of): Glioblastoma</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>						
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year				
Medical Certificate: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension Seizure Disorder					23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			23f. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide	28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
	29b. Signature and title of certifier 	29c. License number D0023322	29d. Date signed (Month, Day, Year) 3.2.2012				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. S Sachdev MD, 1264, Elkhorn St, Elkton MD 21921						
	31. Date filed (Month, Day, Year) MAR 12 2012	32. Registrar's Signature 					

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07589

1- For State Registrar**Physician/Medical Examiner**

1. Decedent's Name (First, Middle, Last) Gaylon Ann Knipe				2. Date of Death Month Day Year February 26, 2012		3. Time of Death 1140 hrs
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Funeral Director

4a. Facility Name (if not institution, give street and number) 4109 53rd Place				4b. City, Town, or Location of Death Bladensburg		4c. County of Death Prince George's	
5. Social Security Number Unav		6. Sex M	7. Age (In yrs. last birthday) 58	If Under 1 Year Months 0	If Under 24 Hrs. Days 0	8. Date of Birth (MM/DD/YYYY) May 1, 1953	9. Birthplace (State or Foreign Country) San Diego, California

10a. State Maryland				10b. County Prince George's		10c. City, Town or Location Bladensburg		10d. Inside City Limits Yes
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10e. Street and Number 4109 53rd Place				10f. Zip Code 20710		10g. Citizen of What Country? USA		
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11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: White		14. Race - American Indian, Black, White, etc.	
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15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home			
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17. Father's Name (First, Middle, Last) Robert Gaylon Knipe				18. Mother's Name (First, Middle, Maiden Surname) Gene Wright			
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19a. Informant's Name/Relationship (Type, Print) Jessica L. Knipe / Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4109 53rd Place, Bladensburg, MD 20710					
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20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:		20b. Place of Disposition (Name of cemetery, crematory or other place) Mount Olivet Cemetery		Date 3/5/2012	20c. Location - City or Town, State Washington, DC		
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21. Signature of Funeral Service Licensee Ray Rogers- M01423 per dvr		22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781					
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23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
a. <u>Methadone and Cocaine Intoxication</u> Due to (or as a consequence of):							
b. _____ Due to (or as a consequence of):							
c. _____ Due to (or as a consequence of):							
d. _____							
<input checked="" type="checkbox"/> UNPENDED		<input checked="" type="checkbox"/> AMENDED 21 per fh g925 3-12-12 vt 23a.27.28a-f.per me.g925 3-14-12 sm					

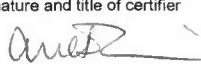
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input checked="" type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year			
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
_____		_____		24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	

25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene					
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27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input checked="" type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) fd 2-26-12		28b. Time of Injury fd 11:25 am		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	28d. Describe how injury occurred unknown
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Found: Residence		28f. Location (Street and Number or Rural Route Number, City or Town, State) 4109 53rd Place Bladensburg, MD			

29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29d. Date signed (Month, Day, Year) February 27, 2012			
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29b. Signature and title of certifier 				29c. License number O.C.M.E.			
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30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223							
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31. Date filed (Month, Day, Year) MAR 07 2012		32. Registrar's Signature 					
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Baltimore, MD 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Medical Certification: To Be Completed by Physician/Medical Examiner**State Registrar**

DHMH 17 Rev 1/2001

OCME 2006

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07590

1 - For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Emilie Carol Kristek				2. Date of Death Month February Day 25 , Year 2012	3. Time of Death 2:24 PM	
	4a. Facility Name (if not institution, give street and number) 16218 Lappans Road		4b. City, Town, or Location of Death Williamsport		4c. County of Death Washington		
Funeral Director	5. Social Security Number 219-66-0126	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 57 Yrs.	If Under 1 Year Months 10	If Under 24 Hrs. Days 13	8. Date of Birth (Month, Day, Year) 10/13/1954	9. Birthplace (State or Foreign Country) MD
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State MD 10b. County Washington 10c. City, Town or Location Williamsport				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 16218 Lappans Road		10f. Zip Code 21795		10g. Citizen of What Country? USA		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)	Machine Operator	16b. Kind of Business Industry Insulation			
	17. Father's Name (First, Middle, Last) Thomas Lingo	18. Mother's Name (First, Middle, Maiden Surname) Mary Louise					
	19a. Informant's Name/Relationship (Type, Print) Diana P. Nave / Companion	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16218 Lappans Road, Williamsport, MD 21795					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) Smithsburg Crematorium	20b. Place of Disposition (Name of cemetery, crematory or other place) Smithsburg Crematorium	Date 2/27/2012	20c. Location - City or Town, State Smithsburg, MD			
	21. Signature of Funeral Service Licensee 	22. Name and Address of Facility Gerald N. Minnich Funeral Home 305 N. Potomac St., Hagerstown, MD 21740					

Physician/ Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Severe chronic obstructive pulmonary disease				Approximate Interval Between Onset and Death years			
	<p>a. Due to (or as a consequence of): Severe chronic obstructive pulmonary disease</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Anxiety, depression				23e. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
					<p>24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</p> <p>24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>			
	25. Was case referred to me as my examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOD Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide	28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred			
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier 	29c. License number B 41786		29d. Date signed (Month, Day, Year) 2/27/12				
	30. Name and address of person who completed cause of death (Item 23) (Type, Print) J. Allen Henry MD, 12821 oak hill ave, Hagerstown MD 21742							
	31. Date filed (Month, Year) FEB 28 2012	32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07591

1 - For
State
RegistrarPhysician/
Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

King, Anita
Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
Anita Coltrane King		Month	Day	Year
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
Doctors Community Hospital		Lanham		Prince George's
5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months Days Hours Min.
578-22-8542		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	94 Yrs.	8. Date of Birth (Month, Day, Year)
Usual Residence of Decedent				11/24/1917
10a. State		10b. County	10c. City, Town or Location	10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
Md.		P.G.	Clinton	
10e. Street and Number		10f. Zip Code		10g. Citizen of What Country? U.S.A.
6107 Hellen Lee Drive		20735		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cook		16b. Kind of Business/Industry D.C. Public Schools
17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)		Ruth McLendon
Harrison Coltrane		19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6107 Hellen Lee Dr., Clinton, Maryland 20735
Hugh F. King, Jr./Son		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Ft. Lincoln Cem.
21. Signature of Funeral Service Licensee <i>Jerry H. Pratt</i> CC0316		20c. Date		20c. Location - City or Town, State Brentwood, Maryland
		03/01/12		
23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		22. Name and Address of Facility Henry S. Washington & Sons Co., Inc. 4925 Burroughs Ave., N.E., Washington, D.C. 20019		Approximate Interval Between Onset and Death
<p>a. <i>Pneumonitis</i> Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Coronary artery disease</i> <i>Diabetes</i>		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		23f. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28d. Describe how injury occurred	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <i>D0042684</i>		29d. Date signed (Month, Day, Year) <i>2/23/12</i>
29b. Signature and title of certifier <i>Jay Zwally, MD</i>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Dr. Jay Zwally, 8118 Good Luck Road, Lanham, MD. 20706</i>				
31. Date filed (Month, Day, Year) <i>FEB 27 2012</i>		32. Registrar's Signature <i>Janice J. Parker</i>		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07592

1- For
State
Registrar

Physician/
Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

7

State
Registrar

1. Decedent's Name (First, Middle, Last)		2. Date of Death				3. Time of Death			
Mildred Keck		Month February Day 25 Year 2012				M			
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death				4c. County of Death			
Nimhurt Hospital		Randallstown				Baltimore			
5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year		8. Date of Birth		9. Birthplace (State or Foreign Country) MD	
216-09-1848		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	92 Yrs.	Months	Days	Hours	Min.	Month 1 Year 26	10. Inside City Limits
Usual Residence of Decedent									
10a. State	10b. County	10c. City, Town or Location				10d. Inside City Limits			
MD	Baltimore	Baltimore				1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number		10f. Zip Code				10g. Citizen of What Country?			
2218 Southland Road		21207				United States			
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)		14. Race - American Indian, Black, White, etc. Specify: White			
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:					
15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)				16b. Kind of Business Industry			
Elementary/Secondary (0-12) 12		Homemaker				Own Home			
17. Father's Name (First, Middle, Last)					18. Mother's Name (First, Middle, Maiden Surname)				
Nathaniel Wingate					Harriett Weitzel				
19a. Informant's Name/Relationship (Type, Print)					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)				
Margo Bryant/ Personal Rep.					5317 Springlake Way Baltimore, MD 21212				
20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)			Date		20c. Location - City or Town, State		
X Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		Woodlawn Cemetery			3-3-2012		Woodlawn, MD		
21. Signature of Funeral Service Licensee		22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043							
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
Immediate Cause (Final disease or condition resulting in death)									
Approximate Interval Between Onset and Death									
ASCVD									
a. Due to (or as a consequence of): Diabetes									
b. Due to (or as a consequence of):									
c. Due to (or as a consequence of):									
d.									
IF FEMALE:		23c. If yes, outcome of pregnancy							
23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown							
23d. Date of delivery		Month Day Year							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
Possible GI bleed									
23e. Did tobacco use contribute to the cause of death?									
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown									
24a. Was an autopsy performed?		24b. Were autopsy findings available prior to completion of cause of death?							
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner?		26. Place of Death (Check only one)							
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death		28a. Date of injury (Month, Day, Year) 28b. Time of injury M 28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28d. Describe how injury occurred							
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							
28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier		1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier		29c. License number D72317							
FEB 27 2012		29d. Date signed (Month, Day, Year) February 25, 2012							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		Pamela Reed, MS 5001 Old Court Road Randallstown MD 21133							
31. Date filed (Month, Day, Year)		32. Registrar's Signature							
FEB 27 2012		Teresa S. Park							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07593

1 - For
State
Registrar

Physician/
Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completed filled in by the funeral director, page 2 should be detached for use as the burial-transit
8

Medical Certificate: To Be Completed by Physician/Medical Examiner

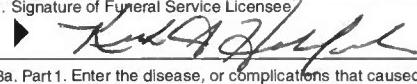
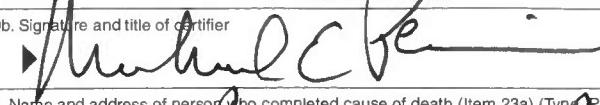
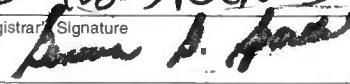
1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death Hour Min. M
<i>Marie Lofton</i>		<i>February 16 2012</i>		<i>158 PM</i>
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
<i>Northwest Hospital</i>		<i>Randallstown</i>		<i>Baltimore</i>
5. Social Security Number	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 93 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 1-20-1919
217-18-9359				9. Birthplace (State or Foreign Country) Maryland
Usual Residence of Decedent				
10a. State MD	10b. County Baltimore	10c. City, Town or Location Randallstown		
10e. Street and Number 4225 Hanwell Rd.		10f. Zip Code 21133		10g. Citizen of What Country? United States
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) 12	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Administrative Assistant	16b. Kind of Business Industry Business		
17. Father's Name (First, Middle, Last) Alfred B. Hughes		18. Mother's Name (First, Middle, Maiden Surname) Margaret Williams		
19a. Informant's Name/Relationship (Type, Print) Judith C. Dickerson/Friend		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4225 Hanwell Road, Randallstown, MD 21133		
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>Lynne McGuire</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory	Date 2/23/2012	20c. Location - City or Town, State Beltsville, MD
21. Signature of Funeral Service Licenssee <i>Lynne McGuire</i>		22. Name and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Avenue, N.W. Wash., D.C. 20012		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Atherosclerotic cardiovascular disease				
Approximate Interval Between Onset and Death				
<p>a. Due to (or as a consequence of): Atherosclerotic cardiovascular disease</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. _____</p>				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown		
23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number DOOS27360		
29b. Signature and title of certifier <i>Laura Julian, MD</i>		29d. Date signed (Month, Day, Year) February 16, 2012		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5401 Old Court Road Randallstown, Maryland 21133 Erica Tsvi				
31. Date filed (Month, Day, Year) FEB 24 2012		32. Registrar's Signature <i>Susan B. Gault</i> MD		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend Items 4a&26 per med cert G926 4/17/12 dk 2012 07594
State of Maryland / Department of Health and Mental Hygiene

1 - For State Registrar

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month Day Year				3. Time of Death	
	FREDERICK EUGENE LEADBETTER				FEBRUARY 20 2012 0431 M					
Funeral Director	4a. Facility Name (If not institution, give street and number)				4b. City, Town, or Location of Death				4c. County of Death	
	CHESTER RIVER HOSPITAL				CHESTERTOWN				KENT	
To Be Completed by Funeral Director	5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) 04/24/1934	9. Birthplace (State or Foreign Country) MAINE	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	005-40-8383									
Usual Residence of Decedent										
10a. State MARYLAND		10b. County KENT		10c. City, Town or Location CHESTERTOWN					10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 101 HOLLY AVENUE				10f. Zip Code 21620				10g. Citizen of What Country? UNITED STATES		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: WHITE			14. Race - American Indian, Black, White, etc.	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 4 PRINCIPAL			16b. Kind of Business/Industry EDUCATION				
17. Father's Name (First, Middle, Last) NORMAN EUGENE LEADBETTER					18. Mother's Name (First, Middle, Maiden Surname) MILDRED GENEVA PORTER					
19a. Informant's Name/Relationship (Type, Print) FRED LEADBETTER, JR. / SON					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 101 HOLLY AVENUE CHESTERTOWN, MARYLAND 21620					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) CHURCH HILL CEMETERY					20b. Place of Disposition (Name of cemetery, crematory or other place) CHURCH HILL CEMETERY			Date 02/28/2012	20c. Location - City or Town, State CHURCH HILL, MARYLAND	
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 130 SPEER ROAD CHESTERTOWN, MARYLAND 21620					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
Immediate Cause (Final disease or condition resulting in death) Mr. - (had) his lymphoma										
Approximate Interval Between Onset and Death										
a. Due to (or as a consequence of): Mr. - (had) his lymphoma										
b. Due to (or as a consequence of):										
c. Due to (or as a consequence of):										
d. Due to (or as a consequence of):										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred				
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier 		29c. License number DOO60301				29d. Date signed (Month, Day, Year) 2/21/12				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MICHAEL REINER MD (22 SPEER RD). CHESTERTOWN MD 21620										
31. Date filed (Month, Day) FEB 22 2012		32. Registrar Signature 								

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28af show any injury or other traumatic event, the Medical Examiner must be notified at once.

12
ns
State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07595

1- For
State
Registrar

Physician/
Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

perm. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Imp. Part: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at one.

Physician/
Medical
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit one.

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death	
Robert Harold Littleton		February 18, 2012				9:00 aM	
4a. Facility Name (if not institution, give street and number) 1712 Crestwood Circle			4b. City, Town, or Location of Death Salisbury			4c. County of Death Wicomico	
5. Social Security Number 218-12-1004		6. Sex 1 XM 2 F	7. Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 03/11/1925	9. Birthplace (State or Foreign Country) Maryland	
10a. State Maryland		10b. County Wicomico		10c. City, Town or Location Salisbury			
10e. Street and Number 1712 Crestwood Circle			10f. Zip Code 21804			10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates. Army		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: 		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) 10			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sales Manager			16b. Kind of Business/Industry Roofing Company	
17. Father's Name (First, Middle, Last) Harold Charles Littleton				18. Mother's Name (First, Middle, Maiden Surname) Mildred Figgs			
19a. Informant's Name/Relationship (Type, Print) Bonnie K. Toadvine/daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 31970 Sierra Dr., Parsonsburg, MD 21849				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) David Thompson CFSP			20b. Place of Disposition (Name of cemetery, crematory or other place) Wicomico Memorial Park		Date 2/24/2012	20c. Location - City or Town, State Salisbury, MD	
21. Signature of Funeral Service Licensee David Thompson CFSP			22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804				
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Due to (or as a consequence of): Chronic obstructive Pulmonary Disease					Approximate Interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23c. Due to (or as a consequence of):					
		23d. Due to (or as a consequence of):					
		23e. Due to (or as a consequence of):					
IF FEMALE:		23f. Due to (or as a consequence of):					
23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23g. Due to (or as a consequence of):					
23h. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23i. Due to (or as a consequence of):					
23j. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23k. Due to (or as a consequence of):					
23l. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23m. Due to (or as a consequence of):					
23n. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23o. Due to (or as a consequence of):					
23p. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23q. Due to (or as a consequence of):					
23r. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23s. Due to (or as a consequence of):					
23t. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23u. Due to (or as a consequence of):					
23v. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23w. Due to (or as a consequence of):					
23x. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23y. Due to (or as a consequence of):					
23z. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23aa. Due to (or as a consequence of):					
23bb. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23cc. Due to (or as a consequence of):					
23dd. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23ee. Due to (or as a consequence of):					
23ff. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23gg. Due to (or as a consequence of):					
23hh. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23ii. Due to (or as a consequence of):					
23jj. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23kk. Due to (or as a consequence of):					
23mm. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23ll. Due to (or as a consequence of):					
23nn. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23oo. Due to (or as a consequence of):					
23pp. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23qq. Due to (or as a consequence of):					
23rr. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23rr. Due to (or as a consequence of):					
23ss. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23tt. Due to (or as a consequence of):					
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23cc. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23cc. Due to (or as a consequence of):					
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23hh. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23hh. Due to (or as a consequence of):					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012

07596

1 - For State Registrar		2. Date of Death Month Day Year				3. Time of Death 9:16 AM					
Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) GEORGE CASIMERE LEMAY				4a. Facility Name (if not institution, give street and number) 210 WYE ROAD					
Funeral Director		4b. City, Town, or Location of Death QUEENSTOWN				4c. County of Death QUEEN ANNES					
To Be Completed by Funeral Director		5. Social Security Number 213-07-0585		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 93 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month Day Year) 01/05/1919	9. Birthplace (State or Foreign Country) CANADA		
		Usual Residence of Decedent 10a. State MD				10b. County QUEEN ANNES				10c. City, Town or Location QUEENSTOWN	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
		10e. Street and Number 210 WYE ROAD				10f. Zip Code 21658				10g. Citizen of What Country? UNITED STATES	
		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates. 1943-1945		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: WHITE	
		15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) 8		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) COLLEGE (1-4 or 5+)		16b. Kind of Business Industry WELDER					
		17. Father's Name (First, Middle, Last) FEU JOSEPH LEMAY				18. Mother's Name (First, Middle, Maiden Surname) LORETTA VARETTI					
		19a. Informant's Name/Relationship (Type, Print) BETTY V. LEMAY / WIFE		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 210 WYE ROAD, QUEENSTOWN, MD 21658							
		20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Entombment		20b. Place of Disposition (Name of cemetery, crematory or other place) OAK LAWN CEMETERY		Date 02/27/2012	20c. Location - City or Town, State BALTIMORE, MD				
		21. Signature of Funeral Service Licensee 		22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWMAN FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619							
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Myocardial infarction				Approximate Interval Between Onset and Death 12 days					
		23b. Part 2. Enter conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
		<p>a. Due to (or as a consequence of): Myocardial infarction</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>									
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) _____ <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year			
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____							
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred				
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							
		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number 00051132							
		29b. Signature and title of certifier 		29d. Date signed (Month, Day, Year) 2-23-12							
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JORGE ABREGO, MD 598 CYNWOOD DRIVE, SUITE 104, EASTON, MD 21601									
State Registrar		31. Date filed (Month, Day, Year) FEB 24 2012		32. Registrar's Signature 							

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit

7/11/12
MS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07597

1- For
State
Registrar

Physician/
Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

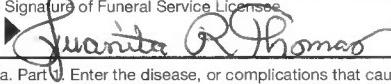
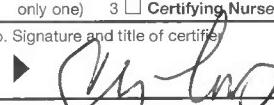
Permit Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

35+

State
Registrar

1- For State Registrar		1. Decedent's Name (First, Middle, Last) Joseph Thomas Lisi, Jr.						2. Date of Death Month February Day 23 , Year 2012		3. Time of Death 7:11 AM	
Physician/ Medical Examiner		4a. Facility Name (if not institution, give street and number) 3718 Restmor Knoll			4b. City, Town, or Location of Death Ellicott City			4c. County of Death Howard			
Funeral Director		5. Social Security Number 203-34-9013		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 67 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) July 21, 1944	9. Birthplace (State or Foreign Country) PA		
To Be Completed by Funeral Director		10a. State MD	10b. County Howard	10c. City, Town or Location Ellicott City			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
		10e. Street and Number 3718 Restmor Knoll			10f. Zip Code 21042			10g. Citizen of What Country? United States			
		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Security Engineer			16b. Kind of Business/Industry IT Security			
		17. Father's Name (First, Middle, Last) Joseph Thomas Lisi, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Antoinette Pasquale					
		19a. Informant's Name/Relationship (Type, Print) Susan Delores Lisi/wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3718 Restmor Knoll Ellicott City, Maryland 21042						
		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Crest Lawn Mem. Gardens			20b. Place of Disposition (Name of cemetery, crematory or other place) Crest Lawn Mem. Gardens			Date 2/29/2012	20c. Location - City or Town, State Marriottsville, MD		
		21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc 4112 Old Columbia Pike Ellicott City, MD 21043						
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
		<p>a. <u>atherosclerosis of the vessels</u> Due to (or as a consequence of): cardiovascular hypertensive disease years</p> <p>b. <u>hypercholesterolemia</u> Due to (or as a consequence of): obesity years</p> <p>c. <u>obesity</u> Due to (or as a consequence of): years</p>									
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year				
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred				
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
		29b. Signature and title of certifier 		29c. License number D42998			29d. Date signed (Month, Day, Year) February 23, 2012				
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cheryl D Leonardi MD 4801 Dorsey Hall Drive Suite 205 Ellicott City Md 21042									
		31. Date filed (Month, Day, Year) FEB 27 2012		32. Registrar's Signature 							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2012 07598

1- For State Registrar

Reg. No.

Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)

Alexander Lee Miron

2. Date of Death

Month Day Year

February 27, 2012

3. Time of Death

0113 hrs

Funeral Director

2002
Baltimore, MD 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State
MD10b. County
Anne Arundel10c. City, Town or Location
Pasadena10d. Inside City Limits
1 Yes 2 No

10e. Street and Number

7711 Zena Marie Lane

10f. Zip Code

21122

10g. Citizen of What Country?
USA

11. Marital Status

1 Never Married 2 Married3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 NoIf Yes, Give Year
or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 Yes 2 No specify:14. Race - American Indian, Black, White, etc.
Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

NA

College (1-4 or 5+)

NA

16a. Decedent's Usual Occupation (Give kind of work done
during most of working life. DO NOT use retired)16b. Kind of Business/Industry
NA

17. Father's Name (First, Middle, Last)

William H. Miron

18. Mother's Name (First, Middle, Maiden Surname)

Jimmie L. Warren

19a. Informant's Name/Relationship (Type, Print)

William Miron/ Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7711 Zena Marie Lane Pasadena, MD 21122

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State4 Donation 5 Other Specify:20b. Place of Disposition (Name of cemetery,
crematory or other place)

MD Veterans Cemetery

Date
March 02,

2012

20c. Location - City or Town, State

Crownsville, MD

21. Signature of Funeral Service Licensee

SPC Dan

22. Name and Address of Facility

Barranco & Sons, P.A. Severna Park Funeral Home
495 Ritchie Hwy, Severna Park, MD 21146**Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) aSudden Unexplained Death In Infancy (SUDI) Due to (or as a consequence of):		
b. Due to (or as a consequence of):		
c. Due to (or as a consequence of):		
d. Due to (or as a consequence of):		
<input type="checkbox"/> UNPENDED	<input type="checkbox"/> AMENDED 23a,27,28a-f,per me,g928 6-4-12 sm	

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown

23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (Specify)
g Unknown

23d. Date of delivery

Month Day Year

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Within 24 hours after death. After this certificate has been signed by the attending physician and To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
		24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
		24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No

25. Was case referred to medical examiner?

1 Yes 2 No

26. Place of Death (Check only one)

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other:

27. Manner of Death

1 Natural 5 Pending Investigation
2 Accident
3 Suicide 6 Could not be determined
4 Homicide

28a. Date of Injury (Month, Day, Year)

fd 2-27-12

28b. Time of Injury

fd 12:00 am

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

unknown

28e. Place of Injury - At home, farm, street, factory, office building, etc.

(Specify)

Found: Residence

28f. Location (Street and Number or Rural Route Number, City or Town, State) 7711 Zena Marie Ln.
Pasadena, MD.29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated.

29b. Signature and title of certifier

Alexander Lee Miron

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

February 27, 2012

30. Name and address of person who completed cause of death (Item 23a)

Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

31. Date filed (Month, Day, Year)

MAR 02 2012

32. Registrar's Signature

*Leanne J. Parks***State Registrar**

1 - For State Registrar

Certificate of Death

Reg. No.

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Michael Joseph Mallen				2. Date of Death Month 2 Day 21 Year 2012	3. Time of Death 5:09 A M		
	4a. Facility Name (if not institution, give street and number) College View Center Nursing		4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick			
Funeral Director	5. Social Security Number 397-58-6373	6. Sex XXM <input type="checkbox"/> F	7. Age (In yrs. last birthday) 60 Yrs.	If Under 1 Year Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min.	8. Date of Birth 9/23/1951	9. Birthplace (State or Foreign Country) Virginia		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State VA 10b. County Loudoun 10c. City, Town or Location Purcellville 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
	10e. Street and Number 36966 Basswood Court		10f. Zip Code 20132		10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: White				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) <input type="checkbox"/> College (1-4 or 5+) 2	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mechanic	16b. Kind of Business Industry National Park Service					
	17. Father's Name (First, Middle, Last) Arthur Mallen		18. Mother's Name (First, Middle, Maiden Surname) Genevieve Lobby					
	19a. Informant's Name/Relationship (Type, Print) Mary Mallen Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 36966 Basswood Court Purcellville VA 20132					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven	Date 2/27/2012	20c. Location - City or Town, State Silver Spring MD			
	21. Signature of Funeral Service Licensee Kimberly Reed		22. Name and Address of Facility 140 S. Nursery Ave. 20134 Hall Funeral Home, Inc Purcellville, VA					
Physician/ Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Amyotrophic lateral sclerosis. Due to (or as a consequence of):						Approximate Interval Between Onset and Death	
	{ b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							
	23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
Medical Certificate: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital: XX inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		Other: 4X Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year) MM/DD/YY	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier Hemen Shah MD		29c. License number D60417		29d. Date signed (Month, Day, Year) 2-23-2012			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hemen Shah MD - 65c Thomas Johnson Dr., Frederick MD 21702							
State Registrar	31. Date filed (Month, Day, Year) FEB 23 2012		32. Registrar's Signature Anna S. Gates					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07600

1 - For
State
Registrar

Physician/
Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Hope Mullen

2. Date of Death

Month Day Year
February 26 2012 112 AM

3. Time of Death

4c. County of Death

CHARLES

Funeral
Director

5. Social Security Number

212-28-4017

6. Sex

1 M 2 F

7. Age (In yrs. last birthday)

90

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)

08-15-1921

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Charles

10c. City, Town or Location

Cobb Island

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

18014 Cypress Drive

10f. Zip Code

20625

10g. Citizen of What Country?

United States

11. Marital Status

1 Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No)
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) 12

College (1-4 or 5+) 12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Healthcare Aide

16b. Kind of Business/Industry

Healthcare

17. Father's Name (First, Middle, Last)

William D. Driver

18. Mother's Name (First, Middle, Maiden Surname)

Mary C. Morgan

19a. Informant's Name/Relationship (Type, Print)

Frances H. Wise/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Box 328 Cobb Island, Maryland 20625

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Holy Ghost Cemetery

Date

03-01-2012

20c. Location - City or Town, State

Issue, Maryland

21. Signature of Funeral Service License

[Signature]

M01458

22. Name and Address of Facility

Arehart-Echols Funeral Home, P.A.

211 St. Mary's Ave. Box 567 La Plata, MD 20646

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of): *Ventricular arrhythmia*

Approximate Interval Between Onset and Death

b. Due to (or as a consequence of): *Cardiomyopathy*

c. Due to (or as a consequence of): *Chronic obstructive lung disease*

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No
9 Unknown

23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify)
9 Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural
2 Accident
3 Suicide
4 Homicide

5 Pending Investigation
6 Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work?
M

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Song C Chon, Md. 7C Post Office Rd. Waldorf, Md 20602

31. Date filed (Month, Day, Year)

FEB 28 2012

2. Registrar's Signature

3. Date filed (Month, Day, Year)

2/26/12

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07601

1 - For
State
RegistrarPhysician/
Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Miller, Joan M 186461
Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) JOAN CAROL MILLER		2. Date of Death Month February Day 24 Year 2012		3. Time of Death 6:05 a.m.	
4a. Facility Name (if not institution, give street and number) Civista Medical Center		4b. City, Town, or Location of Death La Plata		4c. County of Death Charles	
5. Social Security Number 578-481511		6. Sex 1 M 2 XX	7. Age (In yrs. last birthday) 75 Yrs.	If Under 1 Year Months 07	If Under 24 Hrs. Days 16
8. Date of Birth (Month, Day, Year) 07-16-1936		9. Birthplace (State or Foreign Country) WASH., D.C.		10. Inside City Limits 1 Yes 2 XX	
10a. State MD		10b. County ST. MARY'S		10c. City, Town or Location MECHANICSVILLE	
10e. Street and Number 27065 OXLEY DRIVE		10f. Zip Code 20659		10g. Citizen of What Country? UNITED STATES	
11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XX If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 XX No Specify:	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 2 TEACHER		16b. Kind of Business/Industry EDUCATION	
17. Father's Name (First, Middle, Last) EDWARD JOSEPH KRAHLING		18. Mother's Name (First, Middle, Maiden Surname) FREDA LOUISE ESCHBACHER KRAHLING			
19a. Informant's Name/Relationship (Type, Print) CINDY L. ULLMAN / DAUGHTER		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9720 BERRY ROAD, WALDORF, MD 20603			
20a. Method of Disposition 1 XX Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MARYLAND VETERANS CEMETERY		Date MAR. 01, 2012	20c. Location - City or Town, State CHELTENHAM, MD
21. Signature of Funeral Service Licensee TERRENCE L. JOHNSON#M00993		22. Name and Address of Facility TERRENCE L. JOHNSON FUNERAL SERVICE, PA 4433 WHITE PLAINS LANE, WHITE PLAINS, MD			
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
<p>a. Due to (or as a consequence of): Sepsis caused by Endocarditis</p> <p>b. Due to (or as a consequence of): Hypovolemic Shock Syndrome</p> <p>c. Due to (or as a consequence of): Chronic Renal Insufficiency</p> <p>d. Due to (or as a consequence of): Marked Obesity</p>					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown					
24a. Was an autopsy performed? 1 Yes 2 No		24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No			
25. Was case referred to medical examiner? 1 Yes 2 No		26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA		Other: 4 Nursing Home 5 Residence 6 Other (Specify)	
27. Manner of Death 1 Natural 5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide		28a. Date of injury (Month, Day, Year) 28b. Time of injury M		28c. Injury at work? 1 Yes 2 No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred			
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Only one checkmark is required.		29b. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. Signature and title of certifier George J. Johnson M.D.		29c. License number D20629		29d. Date signed (Month, Day, Year) 2/24/12	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) George J. Johnson M.D. WALDORF, MD 20603					
31. Date filed (Month, Day, Year) FEB 28 2012		32. Registrar's Signature Karen S. Park			

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07602

1 - For
State
Registrar

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

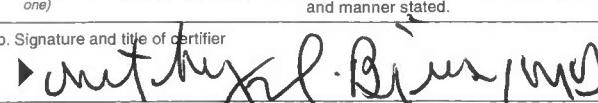
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "Natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death
Michael A. Mason		February 22, 2012		1:43A M
4a. Facility Name (If not institution, give street and number) Heartland of Adelphi		4b. City, Town, or Location of Death Adelphi		4c. County of Death Prince George's
5. Social Security Number 579-58-3487		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 68 Yrs.	If Under 1 Year Months Days Hours Min.
10a. State MD		10b. County Prince George's	10c. City, Town or Location Adelphi	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number 1801 Metzerott Road		10f. Zip Code 20783		10g. Citizen of What Country? United States
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. African American
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Food Services Worker		16b. Kind of Business/Industry WRAMC
17. Father's Name (First, Middle, Last) James Barrington Mason		18. Mother's Name (First, Middle, Maiden Surname) Dolores Marie Willis		
19a. Informant's Name/Relationship (Type, Print) Karen Daniels/Sister		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2615 North Capitol Street, NE Wash., D.C. 20002		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mount Olivet	Date 02/25/2012	20c. Location - City or Town, State Washington, DC
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Ave., N.W. Washington, DC 20012		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death Years		
a. Atherosclerotic Heart Disease Due to (or as a consequence of):				
b. Hypercholesterolemia Due to (or as a consequence of):				
c. Hypertension Due to (or as a consequence of):				
d. _____				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Secondary Hyperparathyroidism Obesity		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29b. Signature and title of certifier 		29c. License number MJ17544		29d. Date signed (Month, Day, Year) 2/22/12
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anthony D. Bivins, MD		31. Date filed (Month, Day, Year) FEB 24 2012		
		32. Registrar's Signature 		

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07603

1- For
State
Registrar

Physician/
Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department. If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last) <i>Elsie Mary Meredith</i>				2. Date of Death Month Day Year 02 22 12 2104 M				3. Time of Death		
4a. Facility Name (If not institution, give street and number) <i>Dennett Road Nursing Home</i>				4b. City, Town, or Location of Death <i>OAKLAND</i>				4c. County of Death <i>GARRETT</i>		
5. Social Security Number <i>233-345971</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>92</i> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	Hours	Min.	8. Date of Birth (Month, Day, Year) <i>1-16-1920</i>	9. Birthplace - State or Foreign Country <i>WV</i>	
10a. State <i>WV</i>		10b. County <i>Grant</i>		10c. City, Town or Location <i>BAYARD</i>						10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number <i>P.O Box 128</i>				10f. Zip Code <i>26707</i>				10g. Citizen of What Country? <i>U.S.A.</i>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates. <i>1920</i>			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <i>White</i>				14. Race - American Indian, Black, White, etc. Specify: <i>White</i>	
15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Bookkeeper</i>				16b. Kind of Business/Industry <i>BANKING.</i>		
17. Father's Name (First, Middle, Last) <i>Raymond J. Gathier</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Bernice E Funk</i>						
19a. Informant's Name/Relationship (Type, Print) <i>Margaret L. Lison</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>9518 Brandonville Rd</i>						
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>BAYARD</i>				20b. Place of Disposition (Name of cemetery, crematory or other place) <i>BAYARD</i>				Date <i>02-23-12</i>	20c. Location - City or Town, State <i>BAYARD, WV</i>	
21. Signature of Funeral Service Licensee <i>Wm A. Hallmark</i>				22. Name and Address of Facility <i>P.O Box 1 Piedmont Wv 26750</i>						

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death <i>years</i>	
<p>a. Due to (or as a consequence of): <i>ALZHEIMERS DISEASE</i></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>			

IF FEMALE:	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____	23d. Date of delivery Month Day Year
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No

25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____			
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27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide	28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	29c. License number <i>1T26154</i>	29d. Date signed (Month, Day, Year) <i>2/22/2012</i>
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Paul Daniel Miller DO</i>	31. Date filed (Month, Day, Year) <i>FEB 24 2012</i>	32. Registrar's Signature <i>Leanne B. Parker</i>
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31. Date filed (Month, Day, Year) <i>FEB 24 2012</i>	32. Registrar's Signature <i>Leanne B. Parker</i>
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5

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07604

1 - For
State
Registrar

Physician/
Medical
Examiner

1. Decedent's Name (First, Middle, Last)		Catherine Theresa Meyers		2. Date of Death Month Month Day Year March 02, 2012	3. Time of Death 6:35 AM
4a. Facility Name (if not institution, give street and number) Frostburg Village Nursing Home		4b. City, Town, or Location of Death Frostburg		4c. County of Death Allegany	
5. Social Security Number 215-20-5910		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 89 Yrs.	If Under 1 Year Months Days Hours Min. If Under 24 Hrs.	8. Date of Birth (Month Day Year) July 19, 1922
Usual Residence of Decedent Maryland		10c. City, Town or Location Allegany		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10a. State Maryland		10b. County Allegany		10f. Zip Code 21532	
10e. Street and Number One Kaylor Circle				10g. Citizen of What Country? USA	
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: 14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 0		16b. Kind of Business Industry Nurses Aide Infirmary	
17. Father's Name (First, Middle, Last) George Augustus Meyers		18. Mother's Name (First, Middle, Maiden Surname) Catherine Douglas			
19a. Informant's Name/Relationship (Type, Print) Michael Meyers - Brother		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21 Kemper Avenue, Westminster, Maryland, 21157			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) ► Brandon W. Helm		20b. Place of Disposition (Name of cemetery, crematory, or other place) St. Mary's Catholic Cemetery		Date March 06, 2012	20c. Location - City or Town, State Lonaconing, Maryland
21. Signature of Funeral Service Licensee ~		22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A. 8 East Main Street Lonaconing, MD 21539			
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		a. <u>CHRONIC OBSTRUCTIVE LUNG DISEASE</u> Due to (or as a consequence of):		Approximate Interval Between Onset and Death	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. _____ Due to (or as a consequence of):	c. _____ Due to (or as a consequence of):	d. _____	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>CONGESTIVE HEART FAILURE</u>				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		23f. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred	
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number D 26907		29d. Date signed (Month, Day, Year) MARCH 02, 2012	
29b. Signature and title of certifier ► Brandon W. Helm					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Yarjit Sidhu, M.D., 925 Bishopfish Road, Cumberland, Maryland, 21502					
31. Date filed (Month, Day, Year) MAR 12 2012		32. Registrar's Signature Suzanne B. Parker			

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

State
Registrar

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07605

1- For State Registrar**Physician/Medical Examiner**

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death 1427 hrs
Roy Roger Manning	February 26, 2012	

Funeral Director

4a. Facility Name (if not institution, give street and number) Meritus Medical Center	4b. City, Town, or Location of Death Hagerstown	4c. County of Death Washington			
5. Social Security Number 215-44-7674	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 66 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (MM/DD/YYYY) January 16, 1946	9. Birthplace (State or Foreign Country) Maryland

To Be Completed by Funeral Director

Baltimore, MD 21215-0036
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
 Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any
 injury or other traumatic event, the Medical Examiner must be notified at once.

10a. State Maryland	10b. County Washington	10c. City, Town or Location Hagerstown	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
10e. Street and Number 1212 Glenwood Avenue		10f. Zip Code 21742	10g. Citizen of What Country? U.S.A.

11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)	16b. Kind of Business/Industry Parts Clerk Appliance Store	

17. Father's Name (First, Middle, Last) Roger Clark Manning	18. Mother's Name (First, Middle, Maiden Surname) Irene Ethel Swartz
--	---

19a. Informant's Name/Relationship (Type, Print) Marlene E. Manning Wife	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1212 Glenwood Avenue, Hagerstown, Maryland 21742
---	---

20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify: <i>R. Noel Brady</i>	20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Lawn Mem. Park	Date 03-02-12	20c. Location - City or Town, State Hagerstown, Maryland
--	--	------------------	---

21. Signature of Funeral Service Licensee <i>R. Noel Brady</i>	22. Name and Address of Facility Andrew K. Coffman Funeral Home, Inc. 40 East Antietam Street, Hagerstown, Md. 21740
---	--

Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.	Approximate Interval Between Onset and Death
--	--	--

<input type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
--	---	---

23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
--	---	---

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
--	--

24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
---	---

25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other: _____	26. Place of Death (Check only one) 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State)
---	--	---	---	---

29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. one 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
--

29b. Signature and title of certifier <i>Melissa Brassell, MD</i>	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) February 27, 2012
--	---------------------------------	--

30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223
--

31. Date filed (Month, Day, Year) FEB 28 2012	32. Registrar's Signature <i>Susan L. Jacob</i>
--	--

Division of Vital Records, P.O. Box 68760,

To the **Attending Physician**: The law requires that the death certificate be executed within 24 hours after death.
 To the **Funeral Director**: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Medical Certification: To Be Completed by Physician/Medical Examiner**State Registrar**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07605

1 - For
State
Registrar

Physician/
Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/
Medical
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

JW-2+1

State
Registrar

Division of Vital Records, P.O. Box 68760

1. Decedent's Name (First, Middle, Last)			2. Date of Death		
James William MELDRON			Month	Day	Year
4a. Facility Name (if not institution, give street and number)			4b. City, Town, or Location of Death		
Meritus Medical Center			Hagerstown		
5. Social Security Number			6. Sex	7. Age (in yrs. last birthday)	
219-36-4775			<input checked="" type="checkbox"/> M <input type="checkbox"/> F	70	Yrs.
Usual Residence of Decedent			If Under 1 Year	If Under 24 Hrs.	
			Months	Days	Hours Min.
10a. State			10b. County		
Maryland			Washington		
10c. City, Town or Location			10d. Inside City Limits		
Hagerstown			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number			10f. Zip Code		
460 McDowell Avenue			21740		
10g. Citizen of What Country?			USA		
11. Marital Status			12. Was Decedent Ever in U.S. Armed Forces?		
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			If Yes, Give Year or Dates: 1957-59		
15. Decedent's Education (Specify only highest grade completed)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		
Elementary/Secondary (0-12) 10			College (1-4 or 5+) 0		
Installer			16b. Kind of Business/Industry Flooring		
17. Father's Name (First, Middle, Last)			18. Mother's Name (First, Middle, Maiden Surname)		
Chester Toms Meldron			Bessie Mae Grove		
19a. Informant's Name/Relationship (Type, Print)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)		
Sonja Meldron - Wife			460 McDowell Avenue, Hagerstown, Md. 21740		
20a. Method of Disposition			20b. Place of Disposition (Name of cemetery, crematory or other place)		
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State			Date		
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			Cedar Laen Mem. Park 3/2/2012		
21. Signature of Funeral Service Licensee			22. Name and Address of Facility Minnich Funeral Home		
<i>Pollitt B. Ronli</i>			415 E. Wilson Blvd. Hagerstown, Md. 21740		
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)					
a. Due to (or as a consequence of): EMPHYSEMA					
b. Due to (or as a consequence of): PNEUMONIA					
c. Due to (or as a consequence of):					
d. Due to (or as a consequence of):					
Approximate Interval Between Onset and Death YEARS					
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
months					
IF FEMALE:		23c. If yes, outcome of pregnancy			
23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown			
23d. Date of delivery					
Month 0 Day 0 Year 0					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23e. Did tobacco use contribute to the cause of death?					
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one)			
Hospital:		Other: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) _____			
27. Manner of Death		28a. Date of injury (Month, Day, Year)		28b. Time of injury	
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		M		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28c. Injury at work?		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier					
<i>GEORGE BAFFOE-BONNIE, MERITUS MEDICAL CENTER</i>					
31. Date filed (Month, Day, Year) FEB 28 2012		32. Registrar's Signature <i>Anne J. Jackson</i>			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

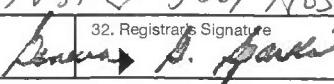
Certificate of Death

Reg. No.

2012 07607

1- For
State
Registrar

Physician/
Medical
Examiner

1. Decedent's Name (First, Middle, Last)		LOUISE MCKAY		2. Date of Death Month Day Year	3. Time of Death
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death	
6630 24th Avenue		Hyattsville		Prince George's	
5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year)
063-48-4960		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	57 Yrs.		MAY 7 1954
Usual Residence of Decedent				9. Birthplace (State or Foreign Country)	
MD		PRINCE GEORGE'S		NEW YORK	
10a. State		10b. County		10c. City, Town or Location	
MD		PRINCE GEORGE'S		HYATTSVILLE	
10e. Street and Number		10f. Zip Code		10g. Citizen of What Country?	
6630 24th AVENUE		20782		USA	
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced					
15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry	
Elementary/Secondary (0-12)		College (1-4 or 5+) 2 yrs		BUDGET ANALYST GOVERNMENT	
17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)			
TIMOTHY MCKAY		ELOISE WRIGHT			
19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
MADALINE MCKAY/SISTER		90 DOWNING STREET #26 BROOKLYN, NEW YORK 11238			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date	20c. Location - City or Town, State
		HARMONY CEMETERY		2/29/2012	LANDOVER, MARYLAND
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785			
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death	
a. Due to (or as a consequence of): <i>Atherosclerotic cardiovascular heart disease</i>					
b. Due to (or as a consequence of):					
c. Due to (or as a consequence of):					
d. Due to (or as a consequence of):					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input checked="" type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Other 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier 		29c. License number 10055927		29d. Date signed (Month, Day, Year) February 27, 2012	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)					
Salvador Sylvester 3001 Hospital Drive, Cheverly, Maryland					
31. Date filed (Month, Day, Year) FEB 28 2012		32. Registrar's Signature 			

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07608

1 - For
State
Registrar

Physician/
Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Betty Ann McKinney

2. Date of Death

Month 02 Day 19 Year 2012

3. Time of Death

11:07 PM

Funeral
Director

4a. Facility Name (if not institution, give street and number)

Coastal Hospice at the Lake

4b. City, Town, or Location of Death

Salisbury

4c. County of Death

Wicomico

5. Social Security Number

218-48-7976

6. Sex

M

F

7. Age (In yrs. last birthday)

64

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Jan 14, 1948

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

MD

Wicomico

10c. City, Town or Location

Hebron

10d. Inside City Limits

Yes No

10e. Street and Number

120 Chapel Branch Drive

21830

10g. Citizen of What Country?

USA

11. Marital Status

Never Married Married
 Widowed Divorced

12. Was Decedent Ever in U.S. Armed Forces?

Yes No
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No)
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Yes No Specify:

14. Race - American Indian, Black, White, etc.

African American

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

County Board of Education

17. Father's Name (First, Middle, Last)

Elwood Taylor

18. Mother's Name (First, Middle, Maiden Surname)

Nancy Selby

19a. Informant's Name/Relationship (Type, Print)

April Price/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5641 Scottish Highlands Circle, Salisbury, MD 21801

20a. Method of Disposition

Burial Cremation Removal from State
 Donation Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Springhill Memory Gardens

Date

2/27/2012

20c. Location - City or Town, State

Hebron, MD

21. Signature of Funeral Service Licensee

Alma Ottobello

22. Name and Address of Facility

Lewis N. Watson Funeral Home, PA
1618 West Rd., Salisbury, MD 21801

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of): MALIGNANT PANCREATIC CANCER

Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
 Yes No
 Unknown

23c. If yes, outcome of pregnancy
 Live Birth Fetal death Ectopic pregnancy
 Pregnant at time of death Other (specify)
 Unknown

23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

Yes No Probably Unknown

25. Was case referred to medical examiner?

Yes No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

Other:

4 Nursing Home 5 Residence 6 Other (Specify)

HOSPITAL

27. Manner of Death

Natural Pending Investigation
 Accident Could not be determined
 Suicide
 Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work?

M 1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

D0058400

02/19/12

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 HILLARY WARREN 1733 ST. SALISBURY MD 21802

31. Date filed (Month, Day, Year)

FEB 22 2012

32. Registrar's Signature

Anna S. Parker

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

2012 07609

1 - For
State
Registrar

Physician/
Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

25. Was case referred to medical examiner?
1 Yes 2 No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death
1 Natural 5 Pending Investigation
2 Accident 6 Could not be determined
3 Suicide 4 Homicide

28a. Date of injury
(Month, Day, Year)

28b. Time of injury

28c. Injury at work?
M 1 Yes 2 No

28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

P.J. Mehta, MD 829 Eastern Shore Dr., Salisbury, MD 21804

31. Date filed (Month, Day, Year)

FEB 22 2012

32. Registrar's Signature

Barbara B. Parker

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1 - For
State
Registrar

Certificate of Death

Reg. No.

2012 07610

Physician/
Medical
Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
AUDREY JOAN MENDENHALL		Month FEB. Day 20 Year 2012		5:30 A M
4a. Facility Name (if not institution, give street and number) 23 BEACONHILL ROAD		4b. City, Town, or Location of Death BERLIN		4c. County of Death WORCESTER
5. Social Security Number 030-24-0056		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 80 Yrs.	8. Date of Birth Month DEC. Day 4 Year 1931
9. Birthplace (State or Foreign Country) MASSACHUSETTS				
10a. State MARYLAND		10b. County WORCESTER	10c. City, Town or Location BERLIN	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
10e. Street and Number 23 BEACONHILL ROAD		10f. Zip Code 21811		10g. Citizen of What Country? USA
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 2 ARTIST		16b. Kind of Business Industry ART
17. Father's Name (First, Middle, Last) FREDERICK CUTTS		18. Mother's Name (First, Middle, Maiden Surname) CHRISTINA MACLEOD		
19a. Informant's Name/Relationship (Type, Print) KAREN J. McCLURE/DAUGHTER		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 41 CLOUCESTER ROAD, OCEAN PINES, MD 21811		
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) CREMATORIAL OF DELMARVA		Date 2/20/12
20c. Location - City or Town, State DELMAR, DELAWARE				
21. Signature of Funeral Service Licensee ► Charles W. Hart		22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975		
23a. Part I. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death		
a. Liver cancer with metastasis. Due to (or as a consequence of):				
b. COPD Due to (or as a consequence of):				
c. Chronic Renal Failure Due to (or as a consequence of):				
d. Anemia Due to (or as a consequence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension		23e. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred
				28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number H 0066462		
29b. Signature and title of certifier ► Jeffrey Robbins DO		29d. Date signed (Month, Day, Year) 2-20-12		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JEFFREY ROBBINS DO 105-14 RACETRACK RD BERLIN MD 21811				
31. Date filed (Month, Day, Year) FEB 23 2012		32. Registrar's Signature Anna S. Farrel		

Baltimore, Maryland 21215-0006

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07611

1 - For
State
RegistrarPhysician/
Medical
Examiner

1. Decedent's Name (First, Middle, Last) Angela Mirizio		2. Date of Death Month 2 Day 25 Year 12		3. Time of Death 11:02AM
4a. Facility Name (if not institution, give street and number) Gilchrist Hospice		4b. City, Town, or Location of Death Columbia		4c. County of Death Howard
5. Social Security Number 216-40-1731		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 76 Yrs.	If Under 1 Year Months Days Hours Min. 8. Date of Birth (Month, Day, Year) June 21, 1935 9. Birthplace (State or Foreign Country) Italy
Funeral Director		Usual Residence of Decedent 10a. State MD 10b. County Howard 10c. City, Town or Location Ellicott City 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
To Be Completed by Funeral Director		10e. Street and Number 11341 Frederick Road		10f. Zip Code 21042 10g. Citizen of What Country? United States
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: White 14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Homemaker		16b. Kind of Business/Industry Own Home
17. Father's Name (First, Middle, Last) Giuseppe Garbo		18. Mother's Name (First, Middle, Maiden Surname) Giuseppa Terracina		
19a. Informant's Name/Relationship (Type, Print) James A. Mirizio/son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21 Winehurst Way Baltimore, MD 21228		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Crest Lawn Mem. Gard.		Date 2/28/12 20c. Location - City or Town, State Marriottsville, MD
21. Signature of Funeral Service Licensee Shawn Glenn - Witzke		22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City MD 21043		
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death 2009		
a. Due to (or as a consequence of): PRIMARY BILIARY CIRRHOSIS				
b. Due to (or as a consequence of):				
c. Due to (or as a consequence of):				
d. Due to (or as a consequence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		23f. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29b. Signature and title of certifier ► 1000 Dr		29c. License number D64395		29d. Date signed (Month, Day, Year) FEBRUARY 25, 2012
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DANIELLE DOBERMAN, MD 6336 CEDAR LANE COLUMBIA, MD 21044		31. Date filed (Month, Day, Year) FEB 27 2012 32. Registrar's Signature Laura J. Parker		

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07612

1- For State Registrar**Physician/Medical Examiner****Funeral Director****To Be Completed by Funeral Director****Baltimore, MD 21215-0036**

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/Medical Examiner**Medical Certification: To Be Completed by Physician/Medical Examiner****Division of Vital Records, P.O. Box 68760,**

To the Physician or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

1. Decedent's Name (First, Middle, Last) Danny Lee Murphy		2. Date of Death Month March Day 2 , Year 2012		3. Time of Death 1010 hrs			
4a. Facility Name (if not institution, give street and number) 29025 Three Notch Road Apt. 3		4b. City, Town, or Location of Death Mechanicsville		4c. County of Death St. Mary's			
5. Social Security Number 215-02-5602	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 29 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.			
				8. Date of Birth (MM/DD/YYYY) 12/12/1982	9. Birthplace (State or Foreign Country) DC		
Usual Residence of Decedent 10a. State MD 10b. County St. Mary's 10c. City, Town or Location Mechanicsville					10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 26694 Laurel Grove Road			10f. Zip Code 20659		10g. Citizen of What Country? USA		
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: White				
14. Race - American Indian, Black, White, etc. Specify: White							
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)		16b. Kind of Business/Industry Plumber Plumbing			
17. Father's Name (First, Middle, Last) Bob Leo Murphy, Jr.			18. Mother's Name (First, Middle, Maiden Surname) Debra Jean (Decatur) Brady				
19a. Informant's Name/Relationship (Type, Print) Kevin Reed Brady / StepFather		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26694 Laurel Grove Road Mechanicsville, MD 20659					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State		20b. Place of Disposition (Name of cemetery, crematory or other place) Trinity Memorial Gard		Date 03/08/2012	20c. Location - City or Town, State Waldorf, MD		
21. Signature of Funeral Service Licensee Mark C. Leiby, Jr.		22. Name and Address of Facility Brinsfield-Echols Funeral Home					
		30195 Three Notch Road Charlotte Hall, MD 20622					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
a. Combined Toxic effects of Methadone, Oxymorphone and Diazepam							
Due to (or as a consequence of):							
b.							
c.							
d.							
<input checked="" type="checkbox"/> UNPENDED		<input checked="" type="checkbox"/> AMENDED #1,23a,pt.II,27,28a-f, per me, g928 6-4-12 sm					
IF FEMALE:		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
Hydrocephalus							
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26 Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other Scene					
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) fd 3-2-12	28b. Time of Injury fd 9:58 am	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	28d. Describe how injury occurred subject took too many medications		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Residence					
29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. one) 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier FOR D. VINCENTI		29c. License number O.C.M.E.			29d. Date signed (Month, Day, Year) March 4, 2012		
30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223							
31. Date filed (Month, Day, Year) MAR 07 2012		32. Registrar's Signature Donna S. Parks					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Amend Items 23aPt1,11,25 per me, g925, 03/08/2012dhp, 30
Certificate of Death

Reg. No. 2012 07613

1- For
State
Registrar

Physician/
Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

Physician/
Medical
Examiner

1. Decedent's Name (First, Middle, Last) <i>Judith Ann McLaughlin</i>				2. Date of Death Month Day Year <i>January 20 2012</i>		3. Time of Death M <i>0937 M</i>	
4a. Facility Name (if not institution, give street and number) <i>Memorial Hospital</i>				4b. City, Town, or Location of Death <i>Easton</i>		4c. County of Death <i>Talbot</i>	
5. Social Security Number <i>216-80-2537</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>44</i> Yrs.	If Under 1 Year Months Days Hours Min.	If Under 24 Hrs.	8. Date of Birth (Month, Day, Year) <i>3-2-1967</i>	9. Birthplace (State or Foreign Country) <i>Md</i>
10a. State <i>MD</i>		10b. County <i>Dorchester</i>		10c. City, Town or Location <i>Cambridge</i>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <i>2303 Hambrook Blvd.</i>				10f. Zip Code <i>21613</i>		10g. Citizen of What Country? <i>USA</i>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>White</i>	
15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Office Manager</i>		16b. Kind of Business/Industry <i>Healthcare</i>			
17. Father's Name (First, Middle, Last) <i>Horace Grayson Peterson</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>Marilyn Francis Eckert</i>					
19a. Informant's Name/Relationship (Type, Print) <i>Johnny McLaughlin/Husband</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2303 Hambrook Blvd. Cambridge MD 21613</i>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>Greenlawn Cemetery 1-25-12 Cambridge, MD</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Greenlawn Cemetery 1-25-12 Cambridge, MD</i>		Date <i>308 High St.</i>	20c. Location - City or Town, State <i>308 High St.</i>		
21. Signature of Funeral Service Licensee <i>Barbara Collins</i>		22. Name and Address of Facility <i>Newcomb and Collins F.H. Cambridge MD 21613</i>					
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Hypertensive Atherosclerotic Cardiovascular Disease</i> Approximate Interval Between Onset and Death							
a. Due to (or as a consequence of) <i>Disease</i>							
b. Due to (or as a consequence of):							
c. Due to (or as a consequence of):							
d. _____							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>① COPD</i> <i>② OSA</i> <i>③ Diabetes Mellitus, Obesity, Cushing's Disease</i> <i>④ H/o Pulmonary Embolism</i>				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		23f. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year) <i>28b. Time of injury M</i> 28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input type="checkbox"/> Medical Examiner <input type="checkbox"/> Certifying Nurse Practitioner		29b. Certification To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <i>DOO 69567</i>		29d. Date signed (Month, Day, Year) <i>Jan, 20, 2012</i>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Ravi Monhan, M.D., Memorial Hospital, Easton, MD</i>							
31. Date filed (Month, Day, Year) <i>MAR 08 2012</i>		32. Registrar's Signature <i>Ravi A. Park</i>					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1 - For State Registrar Amendment #2 per FH 03-02-Certificate of Death

Reg. No.

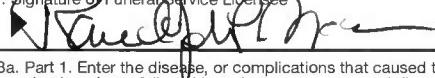
2012 07614

Physician/
Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death
Mildred Lee Nassner		February 26, 2012 February 25, 2012		7:30 A M
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
Homestead Manor		Denton		Caroline
5. Social Security Number	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 80 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) July 29, 1931
216-28-1501				9. Birthplace (State or Foreign Country) Virginia
Usual Residence of Decedent				
10a. State	10b. County	10c. City, Town or Location		
Maryland	Caroline	Denton		
10e. Street and Number 410 Colonial Drive		10f. Zip Code 21629		10g. Citizen of What Country? USA
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) G.E.D.		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerk	16b. Kind of Business Industry Prince George's County	
17. Father's Name (First, Middle, Last) Frederick L. Whitaker		18. Mother's Name (First, Middle, Maiden Surname) Virginia Raine Mills		
19a. Informant's Name/Relationship (Type, Print) Barbara Smith/daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9502 Quail Run Road Denton, Maryland 21629		
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Capitol Crematory	Date 3/2/2012	20c. Location - City or Town, State Dover, Delaware
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Moore Funeral Home, P.A. 12 South Second Street Denton, Maryland 21629		
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)				
<p>a. <i>Probable Incident Lymphoma</i> Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>				
Approximate Interval Between Onset and Death				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>advanced Dementia</i>				
<p>23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown</p> <p>24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <i>Assisted living</i>		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No
		28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier  MD		
29c. License number 00053255		29d. Date signed (Month, Day, Year) 2/28/2012		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Melinda Butler 3683 Chaptank Rd Preston MD 21655				
31. Date filed (Month, Day, Year) FEB 29 2012		32. Registrar's Signature 		

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 687000

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07615

1- For
State
RegistrarPhysician/
Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/
Medical
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

1. Decedent's Name (First, Middle, Last) Stanley F. Nimmo							2. Date of Death Month Day Year FEB. 28, 2012	3. Time of Death 5:55 A.M.		
4a. Facility Name (if not institution, give street and number) Gilchrist Hospice Center				4b. City, Town, or Location of Death Columbia			4c. County of Death Howard			
5. Social Security Number 218-58-2246		6. Sex 1 X M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 61 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	Min.	8. Date of Birth (Month, Day, Year) 01/17/51		9. Birthplace (State or Foreign Country) Maryland	
10a. State MD		10b. County Howard		10c. City, Town or Location Clarksville					10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 X No	
10e. Street and Number 6718 White Gate Road				10f. Zip Code 21029			10g. Citizen of What Country? United States			
11. Marital Status 1 X Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 X No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 X No Specify:			14. Race - American Indian, Black, White, etc. White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 20				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Pharmacy Technician			16b. Kind of Business/Industry Institutional Pharmacy			
17. Father's Name (First, Middle, Last) Richard Stanley Nimmo					18. Mother's Name (First, Middle, Maiden Surname) Eleanor F. Goltenboth					
19a. Informant's Name/Relationship (Type, Print) Ruth E. Nimmo/Sister				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6718 White Gate Rd., Clarksville, MD 21029						
20a. Method of Disposition X Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Hill Crest Cemetery			Date 03/03/12	20c. Location - City or Town, State Federalsburg, Maryland		
21. Signature of Funeral Service Licensee ► Michael F. Gibson				22. Name and Address of Facility Frampton Funeral Home, P.A. 216 N. Main St., Federalsburg, MD 21632						
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									Approximate Interval Between Onset and Death Weeks	
<p>a. END STAGE RENAL DISEASE Due to (or as a consequence of):</p> <p>b. Chronic myelogenous leukemia Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown							23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 X Unknown	
									24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 X No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 X No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 X No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 X Other (Specify) Hospice								
27. Manner of Death 1 X Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred				
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier ► Alynn		29c. License number D0060634			29d. Date signed (Month, Day, Year) 2/28/12					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BINDU JOSEPH, 6336 CEDAR LANE, COLUMBIA, MD 21044										
31. Date filed (Month, Day, Year) MAR 02 2012		32. Registrar's Signature ► [Signature]								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07616

1 - For
State
Registrar

Physician/
Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

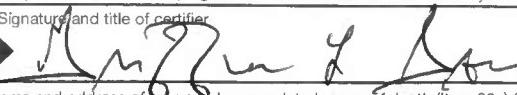
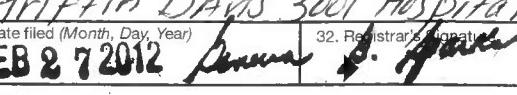
Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death	
Arnold Anthony North, Sr.		Month Day Year		8:16 A.M.	
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death	
Prince Georges Hospital Center		Cheverly		Prince Georges	
5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.
578-50-6300		<input checked="" type="checkbox"/> M <input type="checkbox"/> F	72 Yrs.	Months	Days Hours Min.
8. Date of Birth (Month, Day, Year)		9. Birthplace (State or Foreign Country)		10d. Inside City Limits	
March 14, 1939		Washington, D.C.		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10a. State		10b. County		10c. City, Town or Location	
Maryland		Prince Georges		Hyattsville	
10e. Street and Number		10f. Zip Code		10g. Citizen of What Country?	
5377 Quincy Street; Apt. 1		20784		United States	
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry	
Elementary/Secondary (0-12) 11th grade		College (1-4 or 5+) Special Police Officer		District of Columbia Public Library	
17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)			
William North		Louise Colbert			
19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
Leilani Dionne North (Daughter)		5377 Quincy Street; Apt. 1; Hyattsville, Maryland 20784			
20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date	20c. Location - City or Town, State
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		Chesapeake Crematory, Inc.		Feb. 28, 2012	Beltsville, Maryland
21. Signature of Funeral Service Licensee		22. Name and Address of Facility			
		R. N. Horton Company Morticians, Inc.; 600 Kennedy Street, N.W.; Washington, D.C. 20011			
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. If female: Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	
				23d. Date of delivery Month Day Year	
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		23f. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23g. Did autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)		28b. Time of injury	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
				M	28d. Describe how injury occurred
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29b. Signature and title of certifier 		29c. License number D63688		29d. Date signed (Month, Day, Year) February 20, 2012	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		31. Date filed (Month, Day, Year) FEB 27 2012		32. Registrar's Signature 	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07617

1-For State Registrar**Physician/
Medical Examiner**

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death 1728 hrs
--	------------------------------------	------------------------------

Dermot John O'Neill

4a. Facility Name (if not institution, give street and number) 8806 Monard Drive	4b. City, Town, or Location of Death Silver Spring	4c. County of Death Montgomery
---	---	-----------------------------------

Funeral Director

5. Social Security Number 219-15-2906	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 37 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (MM/DD/YYYY) Nov. 13, 1974	9. Birthplace (State or Foreign Country) Wash. DC
--	--	---	---	--	--

To Be Completed by Funeral Director

Usual Residence of Decedent			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10a. State Md.	10b. County Montgomery	10c. City, Town or Location Silver Spring			

10e. Street and Number 2014 Osborn Drive	10f. Zip Code 20910	10g. Citizen of What Country? U.S.A
---	------------------------	--

11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify:	14. Race - American Indian, Black, White, etc. Specify: White
--	---	---	--

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Self-Employed	16b. Kind of Business/Industry Towing Company
---	--	--

17. Father's Name (First, Middle, Last) Jeremiah A. O'Neill	18. Mother's Name (First, Middle, Maiden Surname) Ellen Foley
--	--

19a. Informant's Name/Relationship (Type, Print) Maeve O'Neill/Sister	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2014 Osborn Drive Silver Spring, Maryland 20910
--	---

20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:	20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery	Date Feb. 24, 2012	20c. Location - City or Town, State Silver Spring, Md.
--	---	-----------------------	---

21. Signature of Funeral Service Licensee Henry J. Ladd	M00215	22. Name and Address of Facility DeVol Funeral Home 2222 Wisconsin Ave. N.W. Washington, D.C. 20007
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Baltimore, MD 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 2a or 2b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

**Physician
Medical Examiner****Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and Death
---	--

Immediate Cause (Final disease or condition resulting in death) a. Hanging

Due to (or as a consequence of):

b. _____

Due to (or as a consequence of):

c. _____

Due to (or as a consequence of):

d. _____

<input type="checkbox"/> UNPENDED	<input type="checkbox"/> AMENDED
-----------------------------------	----------------------------------

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
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1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
---	--

24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
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25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene
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27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input checked="" type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day, Year) FOUND: Feb 19, 2012	28b. Time of Injury FOUND: 1715 hrs	28c. Injury at Work? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred Subject hanged self
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28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Auto Garage	28f. Location (Street and Number or Rural Route Number, City or Town, State) 8806 Monard Drive, Silver Spring, MD
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29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. one) 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
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29b. Signature and title of certifier Mary G. Ripple, MD. Deputy Chief Medical Examiner	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) February 20, 2012
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30. Name and address of person who completed cause of death (Item 23a) Mary G. Ripple, MD. Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223
--

31. Date filed (Month, Day, Year) FEB 24 2012	32. Registrar's Signature Lorraine P. Farrel
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OCME**State
Registrar**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07618

1- For
State
RegistrarPhysician/
Medical
Examiner

Baltimore, Maryland 21215-0036
 Permit: Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) Everett Eugene O'Brien			2. Date of Death Month Day Year Feb. 20, 2012	3. Time of Death 16:06 PM
4a. Facility Name (if not institution, give street and number) Garrett County Memorial Hosp.			4b. City, Town, or Location of Death Oakland	4c. County of Death Garrett
5. Social Security Number 215-34-4468		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F 7. Age (In yrs. last birthday) 76 Yrs.	If Under 1 Year Months Days Hours Min. If Yes, Give Year or Dates.	8. Date of Birth (Month, Day, Year) NOV. 23, 1935
9. Birthplace (State or Foreign Country) Maryland			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10a. State MD		10b. County Garrett	10c. City, Town or Location Swanton	
10e. Street and Number 4896 Bittinger Road			10f. Zip Code 21561	10g. Citizen of What Country? U.S.A.
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Farmer & Heavy Equip. Operator	16b. Kind of Business Industry Farming & Construction	
17. Father's Name (First, Middle, Last) Adolphus E. O'Brien			18. Mother's Name (First, Middle, Maiden Surname) Fannie M. Bernard	
19a. Informant's Name/Relationship (Type, Print) Lisa A. Broadwater/ Daug.			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 184 Englewood Lane, Grantsville, MD 21536	
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of place or name of other place) Countryside Crematory	Date 2/25/2012
21. Signature of Funeral Service Licenses 			20c. Location - City or Town, State Davidsville, PA	
22. Name and Address of Facility Newman Funeral Homes P.A. 179 Miller St., Grantsville, MD 21536				

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death <i>Anterior esophageal curvature was a cause of death</i>	
Sequentially list conditions, if any, leading to the immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			
<p>a. Due to (or as a consequence of): <i>Anterior esophageal curvature was a cause of death</i></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. _____</p>			

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No g <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ g <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No

25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work? M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number H26154	29d. Date signed (Month, Day, Year) 2/21/12
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30. Name and address of person who completed cause of death (Item 29a) (Type, Print) P. Daniel Miller DO 69 Wolf Acres Dr., Oakland, MD 21550			
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31. Date filed (Month, Day, Year) FEB 28 2012	32. Registrar's Signature
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07619

1- For
State
Registrar

Physician/
Medical
Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death	3. Time of Death
Daniel Cameron Powell, Sr.	Month Feb.	Day 22
	Year 2012	8:30 A M

4a. Facility Name (if not institution, give street and number)

2760 Guard Road

4b. City, Town, or Location of Death

Federalsburg

4c. County of Death

Caroline

Funeral
Director

5. Social Security Number	8. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign Country)
215-28-5568	<input checked="" type="checkbox"/> M <input type="checkbox"/> F	81 Yrs.	Months	Days	(Month, Day, Year) Oct. 15, 1930	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Caroline	Federalsburg	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

10e. Street and Number

2760 Guard Road

10f. Zip Code

21632

10g. Citizen of What Country?

United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business Industry
Elementary/Seconday (0-12)	College (1-4 or 5+) 2	Automotive Salesman

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Ralph Powell	Anna Seabore

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Ann C. Powell/Spouse	2760 Guard Road, Federalsburg, MD 21632

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	Mt. Joy Lutheran Ch. Cem.	03/2012	Gettysburg, PA

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Michael F. Eskow	Frampton Funeral Home, P.A. 216 N. Main St., Federalsburg, MD 21632

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	1 hour

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consequence of): Hypotension
	b. Due to (or as a consequence of): Cerebral Edema
	c. Due to (or as a consequence of):
	d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) _____ 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
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	23f. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
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25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA	Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)
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27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work? M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
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	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
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29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	29c. License number	29d. Date signed (Month, Day, Year)
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29b. Signature and title of certifier John A. Appelt D.O.	29c. License number H0447522	29d. Date signed (Month, Day, Year) Feb 22nd, 2012
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
3304 Hayman Drive Federalsburg MD 21632

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 23 2012	John A. Appelt D.O.

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

2012 07620

1- For State Registrar		2. Date of Death Month 02 Day 24 Year 2012								3. Time of Death 12:19 p M
Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) Melvin Lewis Paugh				4b. City, Town, or Location of Death Swanton				4c. County of Death Garrett
Funeral Director		4a. Facility Name (if not institution, give street and number) 3035 Walnut Bottom Road			4b. City, Town, or Location of Death Swanton			4c. County of Death Garrett		
To Be Completed by Funeral Director		5. Social Security Number 213-24-6214		6. Sex 1 X M 2 F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) 03 06 1928	9. Birthplace (State or Foreign Country) Maryland	
		10a. State MD		10b. County Garrett		10c. City, Town or Location Swanton			10d. Inside City Limits 1 □ Yes 2 X No	
		10e. Street and Number 3035 Walnut Bottom Road				10f. Zip Code 21561			10g. Citizen of What Country? USA	
		11. Marital Status 1 □ Never Married 2 X Married 3 □ Widowed 4 □ Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates. 1946 1947		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 X No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) tractor operator		16b. Kind of Business/Industry manufacturing				
		17. Father's Name (First, Middle, Last) unknown				18. Mother's Name (First, Middle, Maiden Surname) Mabel Paugh				
		19a. Informant's Name/Relationship (Type, Print) Elizabeth Paugh-wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3035 Walnut Bottom Road, Swanton, MD 21561			Date 2/27/2012		20c. Location - City or Town, State Swanton, MD	
		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) ► David A. Burdock		20b. Place of Disposition (Name of cemetery, crematory or other place) Turner Cemetery						
		21. Signature of Funeral Service Licensee ► David A. Burdock		22. Name and Address of Facility David A. Burdock Funeral Home, PA 21 N 2nd St, Oakland, MD 21550						
Physician/ Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Normal Pressure Hydropsalus								Approximate Interval Between Onset and Death years
		23b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last { a. Due to (or as a consequence of): Normal Pressure Hydropsalus b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		23c. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown			23d. Date of delivery Month Day Year			
Medical Certificate: To Be Completed by Physician/Medical Examiner		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ► Diabetes Hypertension								23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 □ Probably 4 X Unknown
		25. Was case referred to medical examiner? 1 □ Yes 2 X No		26. Place of Death (Check only one) Hospital: 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 □ Nursing Home 5 X Residence 6 □ Other (Specify)			23f. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 X No			
		27. Manner of Death 1 X Natural 5 □ Pending Investigation 2 □ Accident 6 □ Could not be determined 3 □ Suicide 4 □ Homicide		28a. Date of injury (Month, Day, Year) 28b. Time of injury M	28c. Injury at work? 1 □ Yes 2 □ No	28d. Describe how injury occurred				
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) P. Daniel Miller, D.O., 69 Wolf Acres Drive, Oakland, MD 21550		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
		29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 □ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number H26154		29d. Date signed (Month, Day, Year) 2-24-2012				
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P. Daniel Miller, D.O., 69 Wolf Acres Drive, Oakland, MD 21550								
State Registrar		31. Date filed (Month, Day, Year) FEB 28 2012		32. Registrar's Signature Renée J. Parker						

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07621

1 - For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary Janjigian Paraghiamian						2. Date of Death Month 02 Day 22 Year 2012	3. Time of Death 4:15 A M		
	4a. Facility Name (if not institution, give street and number) 9707 Old Georgetown Road Unit 5			4b. City, Town, or Location of Death Bethesda			4c. County of Death Montgomery			
Funeral Director	5. Social Security Number 579 58 3525	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 89 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) 07/31/1922	9. Birthplace (State or Foreign Country) California			
To Be Completed by Funeral Director	10a. State MD	10b. County Montgomery	10c. City, Town or Location Bethesda				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	10e. Street and Number 9707 Old Georgetown Road Unit 5			10f. Zip Code 20814			10g. Citizen of What Country? United States			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher			16b. Kind of Business/Industry Elementary			
	17. Father's Name (First, Middle, Last) Shavarsh Janjigian				18. Mother's Name (First, Middle, Maiden Surname) Louise Tamzarian					
	19a. Informant's Name/Relationship (Type, Print) James Paragamian/son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6204 Kennedy Drive Chevy Chase, MD 20815					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) National Crematory			Date 02/24/2012	20c. Location - City or Town, State Falls Church, VA		
	21. Signature of Funeral Director License 			22. Name and Address of Facility Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave., NW Washington, DC 20016						
Physician/ Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pneumonia								Approximate Interval Between Onset and Death	
	a. Due to (or as a consequence of): Respiratory Failure									
	b. Due to (or as a consequence of):									
	c. Due to (or as a consequence of):									
	d. Due to (or as a consequence of):									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) _____						23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred				
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								29b. Signature and title of certifier 	
	29c. License number D35791								29d. Date signed (Month, Day, Year) 02/23/2012	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Merlyn Vemury MD 9801 Georgia Ave. Suite 227 Silver Spring, MD 20902								31. Date filed (Month, Day, Year) FEB 24 2012	
State Registrar	32. Registrar's Signature 								33. Original	

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial certificate.

Medical Certificate: To Be Completed by Physician/Medical Examiner

4
State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07622

1 - For
State
Registrar

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) Patsy Ann Parks						2. Date of Death Month February Day 29 Year 2012		3. Time of Death 05:25 M			
Funeral Director		4a. Facility Name (if not institution, give street and number) Meritus Medical Center			4b. City, Town, or Location of Death Hagerstown			4c. County of Death Washington					
To Be Completed by Funeral Director		5. Social Security Number 220-34-0719		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 72 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Dec. 6, 1939	9. Birthplace (State or Foreign Country) Maryland				
		Usual Residence of Decedent Maryland Washington		10a. State Maryland 10b. County Washington 10c. City, Town or Location Hagerstown						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
		10e. Street and Number 306 East North Colonial Drive				10f. Zip Code 21742		10g. Citizen of What Country? U.S.A.					
		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White				
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Home					
		17. Father's Name (First, Middle, Last) Ernest R. Socks, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Anna E. King							
		19a. Informant's Name/Relationship (Type, Print) Cynthia A. Mongan (Daughter)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 49 Goller Hill Rd. Hedgesville, WV 25427								
		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Smithsburg Crematory			Date March 1, 2012	20c. Location - City or Town, State Smithsburg, Maryland				
		21. Signature of Funeral Service Licensee 			MO 1414			22. Name and Address of Facility J.L. Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Maryland 21783					
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last											
		<p>a. Due to (or as a consequence of): Cardiorespiratory Failure Approximate Interval Between Onset and Death Few weeks</p> <p>b. Due to (or as a consequence of): Coarctation of Right Lung Few months</p> <p>c. Due to (or as a consequence of): Chronic obstructive pulmonary disease Few years</p> <p>d. Due to (or as a consequence of): Hypertension Disease Few years</p>											
		23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year					
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. GASTRIC TUBE FEEDING ASPIRATION PNEUMONIA											
		23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown											
		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide					
		28a. Date of injury (Month, Day, Year)			28b. Time of injury M		28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred				
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)								
		29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29c. License number D35497			29d. Date signed (Month, Day, Year) 2-29-2012					
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TANVIR A. PASHA, MD 1122 OPAL CT. HAGERSTOWN MD 21740			32. Registrar's Signature 			31. Date filed (Month, Day, Year) MAR 12 2012					

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit permit.

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit permit.

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012

07623

1 - For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

DOROTHY PERKINS

2. Date of Death

Month

Day

Year

3. Time of Death

2:50 PM

4a. Facility Name (If not institution, give street and number)

JOHNS HOPKINS BAYVIEW MEDICAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

FEBRUARY 22 2012

Funeral
Director

5. Social Security Number

215-44-6859

6. Sex

1 M 2 F

7. Age (In yrs. last birthday)

68

Yrs.

If Under 1 Year

If Under 24 Hrs.

Months

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)

AUG. 19, 1943

9. Birthplace (State or Foreign Country)

MARYLAND

To Be Completed by Funeral Director

Usual Residence of Decedent

MD

10b. County

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

 Yes No

10e. Street and Number

2819 GOODWOOD ROAD

10f. Zip Code

21214

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify:
WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

ADMINISTRATOR

16b. Kind of Business/Industry

HEALTH CARE

17. Father's Name (First, Middle, Last)

LOUIS HUNTER PERKINS

18. Mother's Name (First, Middle, Maiden Surname)

DOROTHY KEITH

19a. Informant's Name/Relationship (Type, Print)

JENNIFER ANN EASON/NIECE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

28424 ALMSHOUSE ROAD, OXFORD, MD 21654

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CHESTERFIELD CEMETERY

Date

FEB. 25,
2012

20c. Location - City or Town, State

CENTREVILLE, MD

21. Signature of Funeral Service Licensee

► Chl M. H. [Signature]

22. Name and Address of Facility

FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.
408 S. LIBERTY ST., CENTREVILLE, MD 21617Approximate Interval Between Onset and Death
6 DAYS

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ENTEROBACTER SEPSIS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No
9 Unknown

23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify)
9 Unknown23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

SARCOIDOSIS

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

25. Was case referred to medical examiner?

1 Yes 2 No

26. Place of Death (Check only one)

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 5 Pending investigation
2 Accident 6 Could not be determined
3 Suicide
4 Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07624

1 - For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)							2. Date of Death Month Day Year	3. Time of Death	
	CHARLES JOSEPH PAYNE, JR.							February 24, 2012	10:53 A^M	
Funeral Director	4a. Facility Name (If not institution, give street and number)				4b. City, Town, or Location of Death			4c. County of Death		
	27740 Phoenix Church Road				Marion Station			Somerset		
To Be Completed by Funeral Director	5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 67 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) 09/03/1944	9. Birthplace (State or Foreign Country) New York		
					Hours	Min.				
Usual Residence of Decedent										
Maryland	10b. County		10c. City, Town or Location						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Maryland				Marion Station						
10e. Street and Number 27740 Phoenix Church Road				10f. Zip Code 21838			10g. Citizen of What Country? U.S.A.			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)			16b. Kind of Business/Industry Deck Hand					
17. Father's Name (First, Middle, Last) Charles Joseph Payne		18. Mother's Name (First, Middle, Maiden Surname) Anna Zimmer								
19a. Informant's Name/Relationship (Type, Print) Charles Joseph Payne, III (Son) P. O. Box 591 - Montauk, New York 11954										
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)										
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Crematory of Delmarva			Date		20c. Location - City or Town, State 2/27/2012 Delmar, DE			
21. Signature - Funeral Service Licensee  Robert H. Bradshaw, Jr.		22. Name and Address of Facility Bradshaw & Sons Funeral Home 306 W. Main St. - Crisfield, MD 21817								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)										
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____										
23d. Date of delivery Month Day Year										
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
23f. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide										
28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred										
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)										
28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier 										
29c. License number D 4898										
29d. Date signed (Month, Day, Year) 2/27/2012										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vijay Karumbunathan, M.D. - 201 Hall Highway Crisfield, MD 21817										
31. Date filed (Month, Day, Year) FEB 27 2012		32. Registrar's Signature 								

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07625

1 - For
State
Registrar

1. Decedent's Name (First, Middle, Last)

Bertha Robertson

2. Date of Death

Month

Day

Year

3. Time of Death

Feb. 21, 2012

2:34 P M

Physician/
Medical
Examiner

4a. Facility Name (if not institution, give street and number)

St. Joseph's Ministries

4b. City, Town, or Location of Death

Emmitsburg

4c. County of Death

Frederick

Funeral
Director

5. Social Security Number

579-60-9085

6. Sex

1 M 2 F

7. Age (In yrs. last birthday)

99

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

8. Date of Birth

(Month, Day, Year)

Oct. 7, 1912

Hours

Min.

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Emmitsburg

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

335 South Seton Avenue

10f. Zip Code

21727

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No)
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Seconday (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Business Manager

16b. Kind of Business Industry
Religious Community Daughters of Charity

17. Father's Name (First, Middle, Last)

Thomas Robertson

18. Mother's Name (First, Middle, Maiden Surname)

Bertha Thiele

19a. Informant's Name/Relationship (Type, Print)

Mary Xavier McKenna,

Sister

Servant

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

333 S. Seton Avenue, Emmitsburg, MD 21727

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Joseph's Provincial

Date

2/24/2012

20c. Location - City or Town, State

Emmitsburg, MD

21. Signature of Funeral Service Licensee

John R. Durbaraw

M01191

22. Name and Address of Facility

Myers-Durboraw Funeral Home

210 W Main St., Emmitsburg, MD 21727

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Respiratory Failure

Approximate Interval Between Onset and Death

1 week

Consequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

Chronic Obstructive Lung Disease with Hypoxia

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No

9 Unknown

23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (Specify)

9 Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Asthma

Gastroesophageal Reflux

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural

5 Pending Investigation

2 Accident

6 Could not be determined

3 Suicide

7 Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Alan Carroll MD

29c. License number

D0018705

29d. Date signed (Month, Day, Year)

2/21/12

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alan Carroll MD 310 S. Seton Ave Emmitsburg MD 21727

FEB 23 2012

32. Registrar's Signature

Janice L. Farrel

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

within 24 hours after death.
Important: If item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07626

1- For
State
RegistrarPhysician/
Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

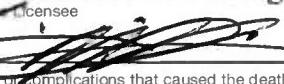
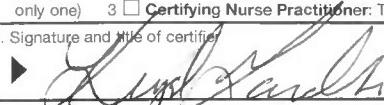
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/
Medical
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

		1. Decedent's Name (First, Middle, Last)			2. Date of Death		3. Time of Death			
		<i>Pauline Mary Elizabeth Reidy</i>			Month <i>February</i> Day <i>25</i> Year <i>2012</i>		9:46 PM			
Physician/ Medical Examiner		4a. Facility Name (if not institution, give street and number)			4b. City, Town, or Location of Death		4c. County of Death			
		<i>The Johns Hopkins Hospital</i>			<i>Baltimore City</i>		<i>Baltimore</i>			
Funeral Director		5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)		
		<i>251-75-1672</i>	<i>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F</i>	<i>57 Yrs.</i>			<i>1-14-1955</i>	<i>England</i>		
		Usual Residence of Decedent			10d. Inside City Limits <i>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</i>					
		10a. State	10b. County	10c. City, Town or Location						
		<i>DE</i>	<i>Kent</i>	<i>Camden-Wyoming</i>						
		10e. Street and Number			10f. Zip Code		10g. Citizen of What Country?			
		<i>3597 Mud Mill Road</i>			<i>19934</i>		<i>USA</i>			
		11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces? <i>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married</i> <i>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</i>	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <i>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</i> Specify: <i>White</i>	14. Race - American Indian, Black, White, etc.					
		15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business/Industry				
		<i>Elementary/Secondary (0-12)</i>	<i>College (1-4 or 5+)</i>	<i>Homemaker</i>			<i>Owned home</i>			
		17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)							
		<i>Alfred Sherratt</i>	<i>Mary Shaw</i>							
		19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)							
		<i>Kelly J. Reidy/Husband</i>	<i>3597 Mud Mill Rd., Camden-Wyoming, DE 19934</i>							
		20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date		20c. Location - City or Town, State				
		<i>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State</i> <i>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</i>	<i>Summit Cremation Services, Inc.</i>	<i>2-27-2012</i>		<i>Wyoming, DE</i>				
		21. Signature of Funeral Service Licensee	22. Name and Address of Facility	23. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.			Approximate Interval Between Onset and Death			
			<i>Pippin Funeral Home, Inc.</i>	<i>End stage Liver Disease</i>						
			22. Name and Address of Facility	<i>119 W. Cam-Wyo Ave., Wyoming, DE 19934</i>						
		23b. Was decedent pregnant in the past 12 months? <i>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</i> <i>9 <input type="checkbox"/> Unknown</i>	23c. If yes, outcome of pregnancy <i>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy</i> <i>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)</i> <i>9 <input type="checkbox"/> Unknown</i>	23d. Date of delivery Month Day Year						
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			23e. Did tobacco use contribute to the cause of death? <i>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown</i>					
								24a. Was an autopsy performed? <i>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</i>	24b. Were autopsy findings available prior to completion of cause of death? <i>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</i>	
		25. Was case referred to medical examiner? <i>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</i>	Hospital:	26. Place of Death (Check only one)						
			<i>1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA</i>	Other: <i>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</i>						
		27. Manner of Death <i>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</i>	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work? <i>M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</i>	28d. Describe how injury occurred				
		<i>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined</i>								
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)		
		29a. Certifier <i>1 <input type="checkbox"/> Certifying Physician 2 <input type="checkbox"/> Medical Examiner 3 <input type="checkbox"/> Certifying Nurse Practitioner</i>	To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
		29b. Signature and title of certifier 	29c. License number		29d. Date signed (Month, Day, Year)					
			<i>RES-000</i>		<i>February 25 2012</i>					
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	<i>Kunjal Gandhi</i>							
		31. Date filed (Month, Day, Year)	<i>FEB 26 2012</i>							
		32. Registrar's Signature								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2012 07627

Reg. No.

1 - For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Lawrence Bernard Rowan							2. Date of Death Month Day Year Feb. 27, 2012	3. Time of Death M A M 1:40 A M	
	4a. Facility Name (if not institution, give street and number) Caroline Home for Hospice			4b. City, Town, or Location of Death Denton			4c. County of Death Caroline			
Funeral Director	5. Social Security Number 119-14-1007		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (in yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 12/31/27	9. Birthplace (State or Foreign Country) Pennsylvania			
	Usual Residence of Decedent 10a. State MD		10b. County Caroline		10c. City, Town or Location Federalsburg			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number 4958 Preston Road			10f. Zip Code 21632			10g. Citizen of What Country? United States			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates. 4 Years		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Engineer			16b. Kind of Business Industry E.I. DuPont			
	17. Father's Name (First, Middle, Last) James Patrick Rowan				18. Mother's Name (First, Middle, Maiden Surname) Marie Morris					
	19a. Informant's Name/Relationship (Type, Print) Nancy Beth Rowan/Daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4958 Preston Road, Federalsburg, MD 21632						
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Eastern Sh. Veterans Cem.			20b. Place of Disposition (Name of cemetery, crematory or other place) Eastern Sh. Veterans Cem.			Date 03/02/12	20c. Location - City or Town, State Hurlock, Maryland		
Physician/ Medical Examiner	21. Signature of Funeral Service Licensee Michael J. Eskow			22. Name and Address of Facility Frampton Funeral Home, P.A. Federalsburg, MD 21632						
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) aspiration pneumonia								Approximate Interval Between Onset and Death	
	b. hypoxic encephalopathy									
	c. end stage dementia									
	d. _____									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown						23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
Medical Certificate: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospital							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred				
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	29b. Signature and title of certifier MJ		29c. License number DO053255			29d. Date signed (Month, Day, Year) 2/28/2012				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Melinda Butler 3683 Chaptank Rd Preston MD 21655									
State Registrar	31. Date filed (Month, Day, Year) FEB 28 2012		32. Registrar's Signature J. Eskow							

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07628

1 - For
State
Registrar

Physician/
Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit: Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/
Medical
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month 02 Day 28 Year 2012		3. Time of Death 0520 M
<i>Joan C Ross</i>				
4a. Facility Name (if not institution, give street and number) <i>Shock Trauma Center</i>		4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death <i>Baltimore City</i>
5. Social Security Number <i>212-32-4269</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months Days Hours Min.
8. Date of Birth (Month, Day, Year) <i>1/26/1933</i>		9. Birthplace (State or Foreign Country) <i>Maryland</i>		
10a. State <i>Maryland</i>		10b. County <i>Talbot</i>		10c. City, Town or Location <i>Easton</i>
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
10e. Street and Number <i>700 Port Street</i>		10f. Zip Code <i>21601</i>		10g. Citizen of What Country? <i>USA</i>
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
14. Race - American Indian, Black, White, etc. Specify: <i>White</i>				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <i>2</i> Proofreader		16b. Kind of Business/Industry <i>State Legislature</i>
17. Father's Name (First, Middle, Last) <i>Wilmer Melvin LeBrun</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>Muriel Doris Hamilton</i>		
19a. Informant's Name/Relationship (Type, Print) <i>Rudolph Miller/son-in-law</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>12308 Lewistown Road Cordova, Maryland 21625</i>		
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Capitol Crematory</i>		Date <i>3/1/2012</i>
20c. Location - City or Town, State <i>Dover, Delaware</i>				
21. Signature of Funeral Service Licensee <i>Ronald E. Duncan</i>		22. Name and Address of Facility Moore Funeral Home, P.A. <i>12 South Second Street Denton, Maryland 21629</i>		
23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Subarachnoid Hemorrhage</i> Due to (or as a consequence of): b. <i>Fall</i> Due to (or as a consequence of): c. <i>Respiratory Failure</i> Due to (or as a consequence of): d. <i>Pneumonia</i> Due to (or as a consequence of): Aproximate interval Between Onset and Death <i>1 month</i>				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Respiratory Failure</i> <i>Pneumonia</i>				
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year) <i>2-23-2012</i>	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how injury occurred <i>Fall from Standing</i>
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <i>Nursing Home</i>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <i>700 Port St Easton, MD 21601</i>		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. Signature and title of certifier <i>Rebecca E. Duncan, MD</i>		29c. License number <i>100484</i>		29d. Date signed (Month, Day, Year) <i>02/28/2012</i>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Rebecca E. Duncan, MD</i> 22 S Green St Baltimore, MD 21201				
31. Date filed (Month, Day, Year) <i>Mar 09 2012</i>		32. Registrar's Signature <i>Rebecca E. Duncan</i>		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07629

1 - For
State
RegistrarPhysician/
Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

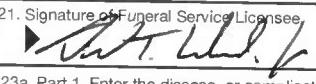
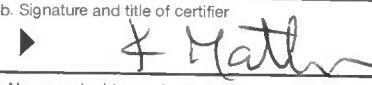
Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/
Medical
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

1. Decedent's Name (First, Middle, Last) Paul Bernard Ratcliffe			2. Date of Death Month 02 Day 25 Year 2012	3. Time of Death 8:00 AM
4a. Facility Name (if not institution, give street and number) 6315 Hidden Valley Drive			4b. City, Town, or Location of Death La Plata	
4c. County of Death Charles			4d. Usual Residence of Decedent Maryland Charles	
5. Social Security Number 579-50-7969			6. Sex 1 XM 2 F	7. Age (In yrs. last birthday) 73 Yrs.
			If Under 1 Year Months	If Under 24 Hrs. Hours Min.
			8. Date of Birth (Month, Day, Year) 08-19-1938	9. Birthplace (State or Foreign Country) Washington D.C.
10a. State Maryland			10b. County Charles	
10c. City, Town or Location La Plata			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 6315 Hidden Valley Drive			10f. Zip Code 20646	
10g. Citizen of What Country? United States				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates.	
13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Program Manager	
16b. Kind of Business/Industry Amtrack				
17. Father's Name (First, Middle, Last) Louis Johnson Ratcliffe			18. Mother's Name (First, Middle, Maiden Surname) Helen Smith	
19a. Informant's Name/Relationship (Type, Print) Carolyn Ratcliffe/Wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6315 Hidden Valley Drive La Plata, Maryland 20646	
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Resurrection Cem.	Date 03-03-2012
20c. Location - City or Town, State Clinton, Maryland				
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Arehart-Echols Funeral Home, P.A. 211 St. Mary's Ave. Box 567 La Plata, MD 20646	
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)			Approximate Interval Between Onset and Death	
a. Chronic lung disease Due to (or as a consequence of):				
b. _____ Due to (or as a consequence of):				
c. _____ Due to (or as a consequence of):				
d. _____				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	
23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
			24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of injury (Month, Day, Year)	28b. Time of injury M
			28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
			28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier 	
			29c. License number 028352	29d. Date signed (Month, Day, Year) 8/27/12
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Po Box 1703 La Plata MD 20646				
31. Date filed (Month, Day, Year) FEB 28 2012			32. Registrar's Signature 	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07630

1- For State Registrar**Physician/
Medical Examiner**

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death 2212 hrs
Connie Sue Bishop Rice - Rice	March 4, 2012	

Funeral Director

4a. Facility Name (if not institution, give street and number) 525 Scravel Road	4b. City, Town, or Location of Death Frederick	4c. County of Death Frederick				
5. Social Security Number 212-96-8169	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 48 Yrs.	If Under 1 Year Months Days Hours Min.	If Under 24 Hrs. Hours Min.	8. Date of Birth (MM/DD/YYYY) 12/13/1963	9. Birthplace (State or Foreign Country) France

Usual Residence of Decedent			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10a. State Maryland	10b. County Frederick	10c. City, Town or Location Frederick				

10e. Street and Number 6094 Quartz Circle	10f. Zip Code 21702	10g. Citizen of What Country? United States
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11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: White	14. Race - American Indian, Black, White, etc. White
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15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)	16b. Kind of Business/Industry Accountant
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17. Father's Name (First, Middle, Last) Carlton Bishop	18. Mother's Name (First, Middle, Maiden Surname) Jennie M. Nunley
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19a. Informant's Name/Relationship (Type, Print) Charles W. Rice / Husband	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 102 Prospect St., Middletown, MD 21769
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20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:	20b. Place of Disposition (Name of cemetery, crematory or other place) Resthaven Crematory	Date March 6, 2012	20c. Location - City or Town, State Frederick, Maryland
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21. Signature of Funeral Service Licensee 	22. Name and Address of Facility Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mountain Hwy. Frederick, MD 21701
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23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Narcotic Intoxication(Methadone, Oxycodone, Morphine) and Cocaine Use	Approximate Interval Between Onset and Death
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Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consequence of): and Cocaine Use
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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): and Cocaine Use
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c. Due to (or as a consequence of): and Cocaine Use	d.
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<input checked="" type="checkbox"/> UNPENDED	<input checked="" type="checkbox"/> AMENDED #1, 23a, 27, 28a-f per me, g926 4-24-12 sm 1 per me g927 3-17-12 vt
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IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input checked="" type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
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25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA fd 3-4-12 fd 9:50 pm	26. Place of Death (Check only one) Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene unknown
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27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input checked="" type="checkbox"/> Could not be determined	28a. Date of Injury (Month, Day, Year) fd 3-4-12	28b. Time of Injury fd 9:50 pm	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	28d. Describe how injury occurred unknown
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28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Apartment	28f. Location (Street and Number or Rural Route Number, City or Town, State) 2525 Scravel Rd. Frederick, MD.
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29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. One	29b. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Two	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) March 5, 2012
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30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

31. Date filed (Month, Day, Year) MAR 07 2012	32. Registrar's Signature Connie S. Bishop
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Baltimore, MD 21215-0036

Important: If item 27 is marked other than "natural", or items 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Medical Certification: To Be Completed by Physician/Medical Examiner**State Registrar**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2012 07631

1- For
State
Registrar

Certificate of Death

Reg. No.

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Martin M Rothstein</i>					2. Date of Death Month 03 Day 05 Year 2012	3. Time of Death 1738 M	
	4a. Facility Name (If not institution, give street and number) <i>WMHS FNRC</i>		4b. City, Town, or Location of Death <i>Frostburg</i>			4c. County of Death <i>Allegany</i>		
Funeral Director	5. Social Security Number 166-09-0512		6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 97 Yrs.	If Under 1 Year Months 0 Days 0	If Under 24 Hrs. Hours 0 Min. 0	8. Date of Birth (Month, Day, Year) Sept 23, 1914	9. Birthplace (State or Foreign Country) Pennsylvania
	10a. State MD		10b. County Allegany		10c. City, Town or Location Frostburg			10d. Inside City Limits 1 X Yes 2 No
To Be Completed by Funeral Director	10e. Street and Number 191 East Main Street			10f. Zip Code 21532			10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 X Never Married 2 M Married 3 W Widowed 4 D Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 D No If Yes, Give Year or Dates. 1940 1945		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 D Yes 2 X No Specify:			14. Race - American Indian, Black, White, etc. Specify: White
	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 8 Medical Doctor - Physician		16b. Kind of Business Industry Medical			
	17. Father's Name (First, Middle, Last) George Rothstein			18. Mother's Name (First, Middle, Maiden Surname) Rose (Inselman) Rothstein				
	19a. Informant's Name/Relationship (Type, Print) Mrs. Anita M. Rothstein			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 188 Society Hill, Cherry Hill, NJ 08003				
	20a. Method of Disposition 1 X Burial 2 C Cremation 3 R Removal from State 4 D Donation 5 O Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Montefiore Cemetery		Date Mar. 6, 2012	20c. Location - City or Town, State Philadelphia, PA		
	21. Signature of Funeral Service Licensee John J. Hafer, Jr.		22. Name and Address of Facility Hafer Funeral Service, PA 1302 National Hwy., LaVale, MD 21502					
Physician/ Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CORONARY ARTERY DISEASE Approximate Interval Between Onset and Death Years							
	<p>a. Due to (or as a consequence of): CORONARY ARTERY DISEASE</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>							
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC KIDNEY DISEASE		23e. Did tobacco use contribute to the cause of death? 1 D Yes 2 C No 3 P Probably 4 X Unknown					
			23f. Were autopsy findings available prior to completion of cause of death? 1 D Yes 2 C No					
	25. Was case referred to medical examiner? 1 C Yes 2 L No		26. Place of Death (Check only one) Hospital: 1 D Inpatient 2 C ER/Outpatient 3 D DOA 4 X Nursing Home 5 C Residence 6 D Other (Specify)				23d. Date of delivery Month Day Year	
	27. Manner of Death 1 X Natural 5 D Pending Investigation 2 C Accident 6 D Could not be determined 3 C Suicide 4 C Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 D Yes 2 C No	28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 C Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 D Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier Jesus Tan		29c. License number D21244			29d. Date signed (Month, Day, Year) 3/5/2012		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Jesus Tan, 4 Broadway, Frostburg, MD 21532							
	31. Date filed (Month, Day, Year) MAR 12 2012		32. Registrar's Signature Jesus S. Sainz					

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07632

For
State
Registrar

Physician/
Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death
<i>Richard Richardson</i>		February 27, 2012		11:15 M
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
<i>Meritus Medical Center</i>		<i>Hagerstown</i>		<i>Washington</i>
5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	8. Date of Birth (Month, Day, Year)
<i>158-34-7855</i>		<input checked="" type="checkbox"/> M <input type="checkbox"/> F	<i>67</i> Yrs.	<i>12/16/1944</i>
9. Birthplace (State or Foreign Country)		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
<i>New York</i>				
10a. State		10b. County	10c. City, Town or Location	
<i>MD</i>		<i>Anne Arundel</i>	<i>Glen Burnie</i>	
10e. Street and Number		10f. Zip Code		10g. Citizen of What Country?
<i>7852 American Circle</i>		<i>21060</i>		<i>USA</i>
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates. <i>1962-65</i>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: <i>Black</i>
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>5+</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Fraud Intended Affairs Invest.</i>		16b. Kind of Business/Industry <i>Government</i>
17. Father's Name (First, Middle, Last) <i>Odel Leonard</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>Edna Richardson</i>		
19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>524 Franklin Square Dr Chambersburg PA 17201</i>		
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) <i>MOS 49</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Duncan Funeral Home Cemetery</i>		20c. Location - City or Town, State <i>Shippensburg Pa</i>
21. Signature of Funeral Service Licensee <i>Paul T Locklear Jr</i>		22. Name and Address of Facility <i>Locust Ampitheater Funeral Home Inc 405 S CHURCH ST, WAYNESBORO PA</i>		
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) <i>THROMBO CYTOPENIA</i>		Approximate Interval Between Onset and Death		
Sequential list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>HEALTH CARE ASSOCIATES PNEUMONIA</i>				
a. Due to (or as a consequence of): <i>SGPS</i>				
b. Due to (or as a consequence of): <i>PULMONARY HEMORRHAGE</i>				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>BLEEDING FROM TRACHEOSTOMY</i>		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> D.O.A Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) <i>CHRONIC RESPIRATORY FAILURE</i>		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <i>D0062006</i>		
29b. Signature and title of certifier <i>[Signature]</i>		29d. Date signed (Month, Day, Year) <i>2/27/12</i>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)				
31. Date filed (Month, Day, Year) <i>FEB 29 2012</i>		32. Registrar's Signature <i>[Signature]</i>		

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07633

1 - For
State
Registrar

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) Clyde Ross, Sr.						2. Date of Death Month <u>February</u> Day <u>19th</u> Year <u>2012</u>		3. Time of Death <u>4:20 A.M.</u>													
Funeral Director		4a. Facility Name (if not institution, give street and number) Prince Georges Hospital Center			4b. City, Town, or Location of Death Cheverly			4c. County of Death Prince Georges															
To Be Completed by Funeral Director		5. Social Security Number 230-26-7250		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) July 8, 1928	9. Birthplace (State or Foreign Country) Virginia														
To Be Completed by Funeral Director		10a. State Maryland	10b. County Prince Georges	10c. City, Town or Location Capitol Heights						10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No													
To Be Completed by Physician/Medical Examiner		10e. Street and Number 1541 Nova Avenue			10f. Zip Code 20743			10g. Citizen of What Country? United States															
To Be Completed by Physician/Medical Examiner		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black														
To Be Completed by Physician/Medical Examiner		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th grade			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Maintenance Engineer			16b. Kind of Business/Industry Hilton Hotels															
To Be Completed by Physician/Medical Examiner		17. Father's Name (First, Middle, Last) Eugene Ferguson			18. Mother's Name (First, Middle, Maiden Surname) Maude Virgil Ross																		
To Be Completed by Physician/Medical Examiner		19a. Informant's Name/Relationship (Type, Print) Ida Elizabeth Johnson Ross (Wife)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1541 Nova Avenue; Capitol Heights, Maryland 20743																		
To Be Completed by Physician/Medical Examiner		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>Ronald L. Smith 0033</i>			20b. Place of Disposition (Name of cemetery, crematory or other place) Heritage Memorial Cemetery			Date Feb. 25, 2012	20c. Location - City or Town, State Waldorf, Maryland														
To Be Completed by Physician/Medical Examiner		21. Signature of Funeral Service Licensee <i>Ronald L. Smith 0033</i>			22. Name and Address of Facility R. N. Horton Company Morticians, Inc.; 600 Kennedy Street, N.W.; Washington, D.C. 20011																		
To Be Completed by Physician/Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cardiopulmonary Collapse									Approximate Interval Between Onset and Death												
To Be Completed by Physician/Medical Examiner		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20%; vertical-align: top; padding: 5px;">a.</td> <td style="width: 60%; vertical-align: top; padding: 5px;">Cardiac Dysrhythmia</td> <td style="width: 20%; vertical-align: top; padding: 5px;">hours</td> </tr> <tr> <td>b.</td> <td>Coronary Artery Disease</td> <td>years</td> </tr> <tr> <td>c.</td> <td></td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table>									a.	Cardiac Dysrhythmia	hours	b.	Coronary Artery Disease	years	c.			d.			
a.	Cardiac Dysrhythmia	hours																					
b.	Coronary Artery Disease	years																					
c.																							
d.																							
To Be Completed by Physician/Medical Examiner		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year															
To Be Completed by Physician/Medical Examiner		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Obstructive Pulmonary Disease Chronic Hypoxemia History of Venothrombosis									23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown												
To Be Completed by Physician/Medical Examiner		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			23f. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown															
To Be Completed by Physician/Medical Examiner		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred															
To Be Completed by Physician/Medical Examiner		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)															
To Be Completed by Physician/Medical Examiner		29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						29b. Signature and title of certifier <i>K. Michael Ross</i>			29c. License number D52865	29d. Date signed (Month, Day, Year) February 19th 2012											
To Be Completed by Physician/Medical Examiner		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) K. Michael Ross MD 12150 Annapolis Rd Ste 200 Glenn Dale, MD 20769																					
State Registrar		31. Date filed (Month, Day, Year) FEB 27 2012			32. Registrar's Signature <i>A. Parker</i>																		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

2012 07634

1 - For State Registrar		1. Decedent's Name (First, Middle, Last) George Calvin Ray							2. Date of Death Month 02 Day 19 Year 12		3. Time of Death 0218 M	
Physician/ Medical Examiner		4a. Facility Name (if not institution, give street and number) Peninsula Regional Medical Center							4b. City, Town, or Location of Death Salisbury		4c. County of Death Wicomico	
Funeral Director		5. Social Security Number 331-24-3644		6. Sex 1 X M 2 □ F		7. Age (In yrs. last birthday) 81 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		
To Be Completed by Funeral Director		8. Date of Birth (Month, Day, Year) 11/27/1930							9. Birthplace (State or Foreign Country) Illinois			
Usual Residence of Decedent		10a. State Maryland 10b. County Wicomico 10c. City, Town or Location Hebron							10d. Inside City Limits 1 X Yes 2 □ No			
		10e. Street and Number 143 Chapel Branch Drive				10f. Zip Code 21830				10g. Citizen of What Country? USA		
		11. Marital Status 1 □ Never Married 2 □ Married 3 X Widowed 4 □ Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates Navy			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 X No Specify:			14. Race - American Indian, Black, White, etc. White	
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) - Fire Fighter			16b. Kind of Business/Industry Baltimore City				
		17. Father's Name (First, Middle, Last) George Washington Ray				18. Mother's Name (First, Middle, Maiden Surname) Nancy Elizabeth Graham						
		19a. Informant's Name/Relationship (Type, Print) Kelly E. Saunders/daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 143 Chapel Branch Dr., Hebron, MD 21830						
		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 X Donation 5 □ Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Anatomy Gifts Registry		Date 2/21/2012		20c. Location - City or Town, State Hanover, MD		
		21. Signature of Funeral Service Licensee [Signature]				22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804						
Physician/ Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)							Approximate Interval Between Onset and Death months			
		a. End stage renal disease Due to (or as a consequence of): congestive heart failure b. Due to (or as a consequence of): pulmonary hypertension c. Due to (or as a consequence of): coronary artery disease							year			
		d. 							year			
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		23c. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown				23d. Date of delivery Month Day Year				
Medical Certificate: To Be Completed by Physician/Medical Examiner		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 □ Probably 4 X Unknown			
									24a. Was an autopsy performed? 1 □ Yes 2 X No			
									24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No			
		25. Was case referred to medical examiner? 1 □ Yes 2 X No		Hospital: 1 X Inpatient 2 □ ER/Outpatient 3 □ DOA		Other: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)		26. Place of Death (Check only one) 1 X Inpatient 2 □ ER/Outpatient 3 □ DOA 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)				
		27. Manner of Death 1 X Natural 5 □ Pending Investigation 2 □ Accident 6 □ Could not be determined 3 □ Suicide 4 □ Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at work? 1 □ Yes 2 □ No		28d. Describe how injury occurred		
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)		
		29a. Certifier (Check only one) 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 □ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
		29b. Signature and title of certifier [Signature]		29c. License number 00059921						29d. Date signed (Month, Day, Year) 2/2/12		
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Brett Hofmann 100 E Carroll St. Salisbury MD 21801										
		31. Date filed (Month, Day, Year) FEB 22 2012		32. Registrar's Signature Laura J. Parks								

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07635

1 - For
State
Registrar

Physician/
Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/
Medical
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10x1
W

1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death	
Erich O. Schnoor		Month February Day 15, 2012 Year		11:10p M	
4a. Facility Name (if not institution, give street and number) 830 Merrick Corner Road		4b. City, Town, or Location of Death Ingleside		4c. County of Death Queen Anne's	
5. Social Security Number 099-14-0501	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 92 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) 01/08/1920
Usual Residence of Decedent					9. Birthplace (State or Foreign Country) Germany
10a. State Maryland	10b. County Queen Anne's	10c. City, Town or Location Ingleside			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number 830 Merrick Corner Road			10f. Zip Code 21644		10g. Citizen of What Country? USA
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates. WW II	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Wood Crafter			16b. Kind of Business/Industry Boat Building
17. Father's Name (First, Middle, Last) Ernest W. Schnoor			18. Mother's Name (First, Middle, Maiden Surname) Marie E. Bulmeister		
19a. Informant's Name/Relationship (Type, Print) Delores Schnoor - Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 830 Merrick Corner Road, Ingleside, MD 21644			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Hillcrest Mem Gardens		Date 2/21/2012	20c. Location - City or Town, State Annapolis, MD
21. Signature of Funeral Service Licensee ► Myelin T. Robert		22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD 21401			
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Chronic congestive heart failure					
Approximate Interval Between Onset and Death 2 years					
<p>a. Due to (or as a consequence of): Chronic congestive heart failure</p> <p>b. Due to (or as a consequence of): Ischemic cardiomyopathy</p> <p>c. Due to (or as a consequence of):</p> <p>d. _____</p>					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown			
23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic atrial fibrillation Chronic obstructive pulmonary disease					
23e. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier ► D. Konick, M.D.		29c. License number D32353		29d. Date signed (Month, Day, Year) February 16, 2012	
30. Name and address of person who completed cause of death (item 23a) (Type, Print) Daniel Konick M.D. 125 Shoreway Dr Suite 120 Queenstown MD 21658					
31. Date filed (Month, Day, Year) FEB 21 2012		32. Registrar's Signature Constance P. Spangler			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07636

1- For State Registrar**Physician/
Medical Examiner**

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death 0610 hrs
Randy Alan Stoudt	March 1, 2012	

Funeral Director

4a. Facility Name (if not institution, give street and number) Montgomery Medical Center	4b. City, Town, or Location of Death Olney	4c. County of Death Montgomery			
5. Social Security Number 074-64-2905	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 41 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (MM/DD/YYYY) 02/08/1971	9. Birthplace (State or Foreign Country) New York

To Be Completed by Funeral Director

Baltimore, MD 21215-0036
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10a. State MD	10b. County Montgomery	10c. City, Town or Location Olney			
10e. Street and Number 17208 Moss Side Lane		10f. Zip Code 20832		10g. Citizen of What Country? United States	

11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify:	14. Race - American Indian, Black, White, etc. Specify: White
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15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 4	16b. Kind of Business/Industry Engineer Investment Co.
---	--	---

17. Father's Name (First, Middle, Last) Unknown	18. Mother's Name (First, Middle, Maiden Surname) Marlene Beaman
--	---

19a. Informant's Name/Relationship (Type, Print) Kelly Davis-Stoudt/ex-wife	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2848 Abbey Manor Circle, Brookeville, MD 20833
--	---

20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify: <i>[Signature]</i>	20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crem	Date 3/4/12	20c. Location - City or Town, State Alexandria, VA
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21. Signature of Funeral Service Licensee <i>[Signature]</i>	22. Name and Address of Facility Muriel H. Barber Funeral Home P.O. Box 5038, Laytonsville, MD 20882
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Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and Death
---	--

Immediate Cause (Final disease or condition resulting in death) a. **Diabetic Ketoacidosis**
Due to (or as a consequence of):

b. _____ Due to (or as a consequence of):
c. _____ Due to (or as a consequence of):
d. _____

<input type="checkbox"/> UNPENDED	<input type="checkbox"/> AMENDED 23a, 27, per me, g925 3-14-12 sm
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Division of Vital Records, P.O. Box 68760,
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
_____	24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
_____	24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No

25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other
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27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)	

29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier <i>[Signature]</i>	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) March 2, 2012
---	---------------------------------	--

30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

31. Date filed (Month, Day, Year) MAR 06 2012	32. Registrar's Signature <i>[Signature]</i>
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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

2012 07637

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1 - For
State
Registrar

1. Decedent's Name (First, Middle, Last)

Lawrence Willis Sellers

2. Date of Death

Month

Day

Year

Physician/
Medical
Examiner

February

26

2012

1628 p.m.

3. Time of Death

TALBOT

Funeral
Director

4a. Facility Name (if not institution, give street and number)

MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

EASTON

4c. County of Death

TALBOT

5. Social Security Number

220-28-1772

6. Sex

1 M 2 F

7. Age (In yrs. last birthday)

79

Yrs.

If Under 1 Year

Months Days Hours Min.

8. Date of Birth

(Month, Day, Year)

April

25, 1932

Maryland

9. Birthplace (State or Foreign Country)

Maryland

10a. State

Maryland

10b. County

Talbot

10c. City, Town or Location

Easton

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

19 Kensington Drive

10f. Zip Code

21601

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 1950
If Yes, Give Year or Dates. to 1954

13. Was Decedent of Hispanic Origin? (Specify Yes or No)
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)
11 H.S. Grad.

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Loan Officer

16b. Kind of Business/Industry

Lending Institution

17. Father's Name (First, Middle, Last)

Joseph Spencer Willis Sellers

18. Mother's Name (First, Middle, Maiden Surname)

Mary Mae Lambden

19a. Informant's Name/Relationship (Type, Print)

Joan Sellers/spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19 Kensington Drive Easton, Maryland 21601

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MD Eastern Shore Vet. Cem.

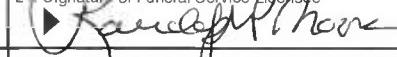
Date

3/1/2012

20c. Location - City or Town, State

Hurlock, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Moore Funeral Home, P.A.

12 South Second Street Denton, Maryland 21629

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death

DAYS

a. PULMONARY HEMORRAGE

Due to (or as a consequence of):

FUNGEMIA

DAYS

b. Due to (or as a consequence of):

RESPIRATORY FAILURE

DAYS

c. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No
9 Unknown

23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (Specify)
9 Unknown

23d. Date of delivery
Month Day Year

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 5 Pending Investigation
2 Accident 6 Could not be determined
3 Suicide
4 Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work?

M

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

only one

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07638

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Roy Curtis Small							2. Date of Death Month February Day 21 Year 2012		3. Time of Death 4:40 p M					
	4a. Facility Name (If not institution, give street and number) Mallard Bay Care Center				4b. City, Town, or Location of Death Cambridge			4c. County of Death Dorchester							
Funeral Director	5. Social Security Number 356-26-7432	6. Sex 1 X M 2 □ F	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	Min.	8. Date of Birth (Month, Day, Year) June 12, 1932	9. Birthplace (State or Foreign Country) Illinois							
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State MD 10b. County Dorchester 10c. City, Town or Location Madison									10d. Inside City Limits 1 □ Yes 2 X No					
	10e. Street and Number 1111 Taylors Island Road				10f. Zip Code 21648			10g. Citizen of What Country? USA							
Physician /Medical Examiner	11. Marital Status 1 □ Never Married 2 X Married	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 X No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 X No Specify:			14. Race - American Indian, Black, White, etc. Specify: white							
	To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 4 owner/operator			16b. Kind of Business/Industry newspaper							
17. Father's Name (First, Middle, Last) Curtis G. Small				18. Mother's Name (First, Middle, Maiden Surname) Margaret Hamdy											
Medical Certification: To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Shelby Jean Small wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1111 Taylors Island Road, Madison, MD 21648			20a. Method of Disposition 1 □ Burial 2 X Cremation 3 □ Removal from State			Date	20c. Location - City or Town, State Delmar, DE				
	4 □ Donation 5 □ Other (Specify) B.C. R			20b. Place of Disposition (Name of cemetery, crematory or other place) Crematory of Delmarva			22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 21613								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) pneumonia											Approximate Interval Between Onset and Death 1 month				
23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 X No											IF FEMALE: 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown	23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. renal failure, diabetes,											23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 □ Probably 4 □ Unknown				
25. Was case referred to medical examiner? 1 □ Yes 2 X No											26. Place of Death (Check only one) Hospital: 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 X Nursing Home 5 □ Residence 6 □ Other (Specify)	24a. Was an autopsy performed? 1 □ Yes 2 X No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No		
27. Manner of Death 1 X Natural 2 □ Accident 3 □ Suicide 4 □ Homicide											28a. Date of Injury (Month, Day, Year) 5 □ Pending investigation	28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred	
											28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) At home			28f. Location (Street and Number or Rural Route Number, City or Town, State) 100 Bramble St, Cambridge, MD	
29a. Certifier (Check only one) 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											29b. Signature and title of certifier B. Johnson			29c. License number H0059973	29d. Date signed (Month, Day, Year) 2/22/12
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P. Johnson											31. Date filed (Month, Day, Year) FEB 28 2012			32. Registrar's Signature Jean S. Park	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2012 07639

Certificate of Death

Reg. No.

1. For
State
RegistrarPhysician/
Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Physician/
Medical
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
<i>Jose' Melendez Slaughter</i>		Month	Day	Year
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
<i>Hospice House</i>		<i>Easton</i>		<i>Talbot</i>
5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>38</i> Yrs.	If Under 1 Year Months Days Hours Min.
<i>216-08-0530</i>				
10a. State <i>MD</i>		10b. County <i>Talbot</i>	10c. City, Town or Location <i>Easton</i>	
10e. Street and Number <i>602 August Street</i>		10f. Zip Code <i>21601</i>		10g. Citizen of What Country? <i>USA</i>
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <i>Black</i>
15. Decedent's Education (Specify only highest grade completed) <i>11</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Dish washer</i>		16b. Kind of Business Industry <i>Restaurant</i>
17. Father's Name (First, Middle, Last) <i>Jose' Melendez</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>Betty Taylor</i>		
19a. Informant's Name/Relationship (Type, Print) <i>Betty Taylor</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>602 August Street - Easton, MD. 21601</i>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>Janelle C Henry</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Slaughter Cemetery</i>	Date <i>3/3/12</i>	20c. Location - City or Town, State <i>Easton, MD.</i>
21. Signature of Funeral Service Licensee <i>Janelle C Henry</i>		22. Name and Address of Facility <i>Henry Funeral Home, P.A. 510 Washington St, Cambridge, MD. 21613</i>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death <i>6 years</i>		
b. Due to (or as a consequence of): <i>Congestive Cardiomyopathy</i> c. Due to (or as a consequence of): <i>Anti-neoplastic Therapy</i> d. Due to (or as a consequence of): <i>Metastatic Breast Cancer</i>				
IF FEMALE:		23d. Date of delivery Month Day Year		
23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Hospice House		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No 28d. Describe how injury occurred
		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
29b. Signature and title of certifier <i>Mary S. De Shields</i>		29c. License number <i>D47232</i>		29d. Date signed (Month, Day, Year) <i>2/28/2012</i>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Mary S. De Shields, MD 509 Idlewild Ave Ste 1 Easton, MD 21601</i>				
31. Date filed (Month, Day, Year) <i>FEB 28 2012</i>		32. Registrar's Signature <i>Anna S. Park</i>		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07640

1- For
State
Registrar

Physician/
Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/
Medical
Examiner

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Medical Certificate: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) EDNA MAE STONEBERGER			2. Date of Death Month Day Year February 29, 2012			3. Time of Death A.M./P.M. 10:20 M						
4a. Facility Name (if not institution, give street and number) Mer. Tivs Medical Center			4b. City, Town, or Location of Death Hagerstown			4c. County of Death Washington						
5. Social Security Number 219-60-4265		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 58 Yrs.		If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) May 29, 1953		9. Birthplace (State or Foreign Country) Pennsylvania				
10a. State Maryland		10b. County Washington		10c. City, Town or Location Smithsburg								
10e. Street and Number 14047 Edgemont Road					10f. Zip Code 21783			10g. Citizen of What Country? U.S.A.				
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Administrative Assistant			16b. Kind of Business/Industry Electrical						
17. Father's Name (First, Middle, Last) Victor M. Otero					18. Mother's Name (First, Middle, Maiden Surname) Mary F. Fox							
19a. Informant's Name/Relationship (Type, Print) David W. Stoneberger				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14047 Edgemont Rd. Smithsburg, Maryland 21783								
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Smithsburg Cemetery			Date March 5, 2012		20c. Location - City or Town, State Smithsburg, Maryland				
21. Signature of Funeral Service Licensee J. L. Davis Funeral Home			MO 1414			22. Name and Address of Facility 12525 Bradbury Ave. Smithsburg, Maryland 21783						
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metastatic Adenocarcinoma												
Approximate Interval Between Onset and Death												
<p>a. Due to (or as a consequence of): { Metastatic Adenocarcinoma }</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>												
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown												
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DCA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred			
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
29b. Signature and title of certifier MARK BAERON, M.D., Hosp. Tivs office			29c. License number 0005307			29d. Date signed (Month, Day, Year) 03/01/2012						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARK BAERON, M.D., Hosp. Tivs office Mer. Tivs Medical Center, Hagerstown, MD												
31. Date filed (Month, Day, Year) MAR 12 2012			32. Registrar's Signature Laura S. Parker									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 0764

1 - For
State
RegistrarPhysician/
Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

1. Decedent's Name (First, Middle, Last) Virtie Stamper		2. Date of Death Month Day Year Feb. 29 2012	3. Time of Death M 8:00AM
4a. Facility Name (if not institution, give street and number) 1606 Redfield Road		4b. City, Town, or Location of Death Bel Air	
4c. County of Death Harford			
5. Social Security Number 226-28-2169		6. Sex <input checked="" type="checkbox"/> XX F	7. Age (In yrs. last birthday) 84 Yrs.
8. Date of Birth (Month, Day, Year) 5/6/1927		9. Birthplace (State or Foreign Country) VA	
10a. State MD		10b. County Harford	10c. City, Town or Location Bel Air
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number 1606 Redfield Road		10f. Zip Code 21015	10g. Citizen of What Country? USA
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker	16b. Kind of Business/Industry Own Home
17. Father's Name (First, Middle, Last) James Monroe Flanagan		18. Mother's Name (First, Middle, Maiden Surname) Rachel Beasley	
19a. Informant's Name/Relationship (Type, Print) Wilbur M. Stamper/Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5747 Glen Oaks Drive, Narvon, PA 17555	
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Slate Ridge	20c. Date 3/4/2012
20c. Location - City or Town, State Delta, PA			
21. Signature of Funeral Services Licensee 		22. Name and Address of Facility Harkins Funeral Home, Delta, PA 17314	
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death Ten years.	
a. <i>Atherosclerotic Cardiovascular Disease</i> Due to (or as a consequence of):			
b. _____ Due to (or as a consequence of):			
c. _____ Due to (or as a consequence of):			
d. _____			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____	
		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M
		28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number d35522	
29b. Signature and title of certifier 		29d. Date signed (Month, Day, Year) February 29, 2012	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARYL WILD 2 NORTHT AVENUE BEL AIR MARYLAND 21014			
31. Date filed (Month, Day, Year) MAR 12 2012		32. Registrar's Signature 	

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07642

1 - For
State
Registrar

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) BETTY JOAN SHAVER					2. Date of Death Month MARCH Day 3 Year 2012		3. Time of Death 5:00A M		
Funeral Director		4a. Facility Name (if not institution, give street and number) WALDORF GENESIS CENTER			4b. City, Town, or Location of Death WALDORF			4c. County of Death CHARLES			
To Be Completed by Funeral Director		5. Social Security Number 578-50-5400 Usual Residence of Decedent		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 73 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) JUNE 1, 1938	9. Birthplace (State or Foreign Country) VIRGINIA		
		10a. State MD	10b. County CHARLES	10c. City, Town or Location WALDORF						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		10e. Street and Number 4044 CHIMNEY SWIFT COURT			10f. Zip Code 20603			10g. Citizen of What Country? U. S. A.			
		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE		
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) ANTIQUE DEALER			16b. Kind of Business/Industry MEMORY LANE ANTIQUES			
		17. Father's Name (First, Middle, Last) ORVILLE FAYE KING				18. Mother's Name (First, Middle, Maiden Surname) SADIE CHILDS					
		19a. Informant's Name/Relationship (Type, Print) PAMELA PERILLO/DAUGHTER			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9270 BILLINGSLEY RD, WHITE PLAINS, MD 20695						
		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) TRINITY MEM.GRDNS			Date MARCH 7, 2012	20c. Location - City or Town, State WALDORF, MARYLAND			
		21. Signature of Funeral Service Licensee 			22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A.						
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)			23b. Due to (or as a consequence of): Colon cancer			Approximate Interval Between Onset and Death			
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			23c. Due to (or as a consequence of): Colon cancer						
		23d. Date of delivery Month Day Year									
		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown									
		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No						
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of injury (Month, Day, Year)			28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
										28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
		29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29c. License number 028352			29d. Date signed (Month, Day, Year) 3-5-12			
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Po Box 1703 Lakewood MD 20646			32. Registrar's Signature Laura B. Hayes			31. Date filed (Month, Day, Year) MAR 12 2012			

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

2012 07643

1- For
State
Registrar

Physician/
Medical
Examiner

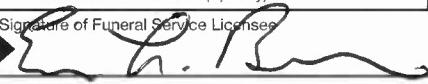
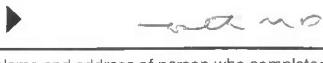
Baltimore, Maryland 21215-0036
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Physician/
Medical
Examiner

Division of Vital Records, P.O. Box 68760
To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and
completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year			3. Time of Death 02:15P M			
Erma Louise Swain			February 25, 2012						
4a. Facility Name (if not institution, give street and number) Homewood at Williamsport			4b. City, Town, or Location of Death Williamsport			4c. County of Death Washington			
5. Social Security Number 213-18-9465		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 91 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) 09/22/1920	9. Birthplace (State or Foreign Country) Maryland		
Usual Residence of Decedent 10a. State Maryland 10b. County Washington 10c. City, Town or Location Williamsport									
10e. Street and Number 16505 Virginia Ave.			10f. Zip Code 21795			10g. Citizen of What Country? U.S.A.			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Proofreader		16b. Kind of Business Industry Bookbinding					
17. Father's Name (First, Middle, Last) Leslie Frank Kephart				18. Mother's Name (First, Middle, Maiden Surname) Louise Jane Ridenour					
19a. Informant's Name/Relationship (Type, Print) Douglas D. Garvin / Son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 637 Birkdale Circle E Niceville, Florida 32578						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Rest Haven Cemetery			Date 02/29/2012	20c. Location - City or Town, State Hagerstown, Maryland			
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave Hagerstown Maryland 21742							
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death Year		
<p>a. <i>ARTERIOSCLEROTIC CARDIO VASCULAR DISEASE</i> Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>INTERSTITIAL CARDIOPULMONARY DISEASE</i> <i>DIABETES MELLITUS HYPERLIPIDEMIA</i> <i>CHRONIC KIDNEY DISEASE</i> <i>DEMENTIA</i>								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29b. Signature and title of certifier 				29c. License number D 18019			29d. Date signed (Month, Day, Year) FEBRUARY 27, 2012		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VASANT DATTA MD 340 MILL ST HAGERSTOWN MD 21742									
31. Date filed (Month, Day, Year) FEB 29 2012		32. Registrar's Signature 							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07644

2012 07644

07644

Physician/ Medical Examiner

**Funeral
Director**

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

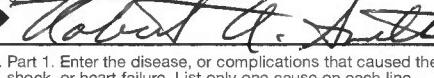
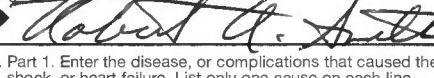
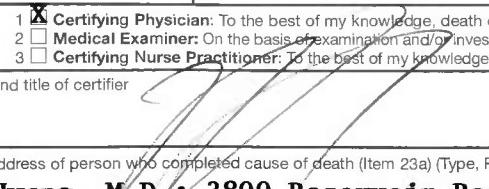
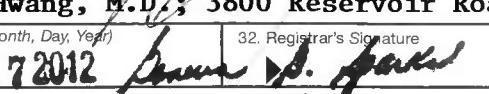
Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

To the Hospital or Attending
within 24 hours after death.
To the Funeral Director: After
completely filled in by the fun-

State
Registrar

1. Decedent's Name (First, Middle, Last) Isaac Samuel Smith, Jr.				2. Date of Death Month February Day 19 , Year 2012	3. Time of Death 2:18 P.M.		
4a. Facility Name (if not institution, give street and number) 1408 Barnacle Geese Court			4b. City, Town, or Location of Death Upper Marlboro				
5. Social Security Number 579-54-4659	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 67 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) April 24, 1944		
Usual Residence of Decedent Maryland	10b. County Prince Georges	10c. City, Town or Location Upper Marlboro	9. Birthplace (State or Foreign Country) Washington, D.C.	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number 1408 Barnacle Geese Court			10f. Zip Code 20774		10g. Citizen of What Country? United States		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? US Air Force Retired 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates Retired		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: Black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Deputy U.S. Marshall		16b. Kind of Business/Industry United States Marshall Services			
17. Father's Name (First, Middle, Last) Isaac Samuel Smith, Sr.			18. Mother's Name (First, Middle, Maiden Surname) Mathilda Pugh				
19a. Informant's Name/Relationship (Type, Print) Rosetta Peoples Smith (Wife)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20774 1408 Barnacle Geese Court; Upper Marlboro, Maryland				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) 		20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington National Cemetery		Date March 1, 2012	20c. Location - City or Town, State Arlington, Virginia		
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility R. N. Horton Company Morticians, Inc.; 600 Kennedy Street, N.W.; Washington, D.C. 20001					
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metastatic Duodenal Cancer						Approximate Interval Between Onset and Death	
<p>a. Due to (or as a consequence of): { b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):</p>							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year) February 24, 2012		28b. Time of injury M		28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) At home		28f. Location (Street and Number or Rural Route Number, City or Town, State) 1408 Barnacle Geese Court, Upper Marlboro, MD 20774			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						29d. Date signed (Month, Day, Year) February 24, 2012	
29b. Signature and title of certifier 		29c. License number MD33109					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jimmy Hwang, M.D.; 3800 Reservoir Road, N. W.; Washington, D.C. 20007						31. Date filed (Month, Day, Year) FEB 27 2012	
32. Registrar's Signature 							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07645

1 - For State Registrar

Physician/
Medical
Examiner

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

		1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death	
		Mary Louise Scott		Month Day Year February 21 2012 0900 M			
Physician/ Medical Examiner		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death	
		PENINSULA REGIONAL MEDICAL CENTER		SALISBURY		WICOMICO	
Funeral Director		5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	
		214-10-9193	1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	95 Yrs.		June 6, 1916	
		Usual Residence of Decedent				9. Birthplace (State or Foreign Country)	
		10a. State	10b. County	10c. City, Town or Location		10d. Inside City Limits	
		MD	WICOMICO	SALISBURY		1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
		10e. Street and Number		10f. Zip Code		10g. Citizen of What Country?	
		300 Lemmon Hill Lane		21801		U.S.A.	
		11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
		1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced					
		15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry	
		Elementary/Secondary (0-12) 12		College (1-4 or 5+) medical secretary		doctors office	
		17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)			
		Roscoe H. Hampshire		Gertrude Wallace			
		19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
		Esther C. Dwyer (Daughter)		7232 Opal Circle Hebron, MD 21830			
Physician/ Medical Examiner		20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date	20c. Location - City or Town, State
		1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) Mardela Memorial Cem.		2-24-2012			Mardela Springs, MD
		21. Signature of Funeral Service Licensee		22. Name and Address of Facility			
		Doris Short Jewell		Short Funeral Home 13 East Grove Street Delmar, DE 19940			
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)				Approximate Interval Between Onset and Death	
		{ a. Due to (or as a consequence of): RSCVD				Years	
		b. Due to (or as a consequence of):					
		c. Due to (or as a consequence of):					
		d. Due to (or as a consequence of):					
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension Hypertensive				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
		25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
		29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
		29b. Signature and title of certifier Christine D. Bounds, MD		29c. License number D58427		29d. Date signed (Month, Day, Year) February 21, 2012	
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Christine D. Bounds, MD 106 N. Bond St 605 Salisbury MD 21804					
		31. Date filed (Month, Day, Year) FEB 22 2012		32. Registrar's Signature Laura S. Parker			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Amend Item 25 per me, g925, 03/22/2012 dbb
Certificate of Death 2012 07646
For State Registrar Reg. No.

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) Sabrina Cathleen Smith								2. Date of Death Month February Day 20 Year 2012		3. Time of Death 0821 M	
Funeral Director		4a. Facility Name (if not institution, give street and number) Meritus Medical Center				4b. City, Town, or Location of Death Hagerstown				4c. County of Death Washington			
To Be Completed by Funeral Director		5. Social Security Number 219-98-0854		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 34 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	Hours	Min.	8. Date of Birth (Month, Day, Year) 09/07/2012	9. Birthplace (State or Foreign Country) Maryland		
		10a. State Maryland		10b. County Washington		10c. City, Town or Location Hagerstown						10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
		10e. Street and Number 671 Highland Way Apt. 3				10f. Zip Code 21740				10g. Citizen of What Country? U.S.A.			
		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 1 Teacher				16b. Kind of Business/Industry Federal Government			
		17. Father's Name (First, Middle, Last) James Thomas Smith				18. Mother's Name (First, Middle, Maiden Surname) Thelma Eleanor Boore							
		19a. Informant's Name/Relationship (Type, Print) Shannon Ann Herrington / sister				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2050 Harris Way Apt. 633 Martinsburg, WV. 25401							
		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Science Care Colorado				20b. Place of Disposition (Name of cemetery, crematory or other place) 03/08/2012				Date	20c. Location - City or Town, State Aurora, Colorado		
		21. Signature of Funeral Service Licensee G. R.				22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave Hagerstown Maryland 21742							
Physician/ Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)				23b. Due to (or as a consequence of): Massive Gastrointestinal Hemorrhage				Approximate Interval Between Onset and Death hours			
		23c. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				23d. Due to (or as a consequence of): Esophageal Varices				months			
		23e. Due to (or as a consequence of): Cirrhosis of the Liver				23f. Due to (or as a consequence of):				months			
		23g. Due to (or as a consequence of):				23h. Due to (or as a consequence of):							
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year					
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Turner's Syndrome				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
						23f. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				23g. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
		25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide					
		28a. Date of injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred					
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)					
		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						29c. License number MDC052136					
		29b. Signature and title of certifier Quinton						29d. Date signed (Month, Day, Year) 2/22/2012					
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 16605 Kendle Road Williamsport MD 21795											
State Registrar		31. Date filed (Month, Day, Year) MAR 09 2012		32. Registrar's Signature Quinton									

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68700

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No. 2012 07647

1 - For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Rodella Jean Swanger							2. Date of Death Month 02 Day 13 Year 2012	3. Time of Death 1540 M		
	4a. Facility Name (if not institution, give street and number) WMHS - Regional Medical Center				4b. City, Town, or Location of Death Cumberland			4c. County of Death Allegany			
Funeral Director	5. Social Security Number 215-26-7517		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) 80 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) Jan 7, 1932	9. Birthplace (State or Foreign Country) MD			
To Be Completed by Funeral Director	10a. State MD		10b. County Allegany		10c. City, Town or Location Rawlings			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	10e. Street and Number 23721 Circle Hill Road				10f. Zip Code 21557		10g. Citizen of What Country? USA				
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cashier			16b. Kind of Business/Industry G.C. Murphy's				
	17. Father's Name (First, Middle, Last) Samuel L. Petenbrink				18. Mother's Name (First, Middle, Maiden Surname) Ella K. Connor						
	19a. Informant's Name/Relationship (Type, Print) Gilbert Swanger son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23721 Circle Hill Road Rawlings MD 21557							
Physician/ Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Scarpelli Funeral Home, P.A.			Date 2/14/2012	20c. Location - City or Town, State Cresaptown MD			
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 2 hr		
	<p>a. Due to (or as a consequence of): <i>Aspiration of gastric contents</i></p> <p>b. Due to (or as a consequence of): <i>Esophageal reflex</i></p> <p>c. Due to (or as a consequence of):</p> <p>d.</p>								<i>year</i>		
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)					23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Sororitis, dysphagia</i>								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA			Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred					
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
	29b. Signature and title of certifier 		29c. License number D0017565			29d. Date signed (Month, Day, Year) Feb. 14, 2012					
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A.J.B. 111-n-078 902 N St. 1 Hwy 101, MD 21502										
State Registrar	31. Date filed (Month, Day, Year) MAR 09 2012		32. Registrar's Signature 								

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND #25, PER MD G930 8/16/12 TRT

State of Maryland / Department of Health and Mental Hygiene

1 - For State Registrar

Certificate of Death

Reg. No.

2012 07648

Physician/
Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

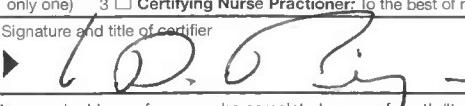
Department of Health and Mental Hygiene
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/
Medical
Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) FLORENCE ALBERTA THORNTON			2. Date of Death Month FEBRUARY Day 13 , Year 2012	3. Time of Death 2:45 P M
4a. Facility Name (If not institution, give street and number) CHESTERTOWN NURSING AND REHAB			4b. City, Town, or Location of Death CHESTERTOWN	
4c. County of Death KENT				
5. Social Security Number 186-07-2256		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 94 Yrs.	8. Date of Birth (Month, Day, Year) 10/12/1917
9. Birthplace (State or Foreign Country) PENNSYLVANIA		10. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
11a. Usual Residence of Decedent 10a. State MD 10b. County KENT 10c. City, Town or Location CHESTERTOWN			10d. Citizen of What Country? UNITED STATES	
10e. Street and Number 97 CLIPPER WAY			10f. Zip Code 21620	
11b. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	
13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE	
15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) BEAUTICIAN	
16b. Kind of Business Industry COSMETOLOGY				
17. Father's Name (First, Middle, Last) CARROLL WEBSTER STEEL			18. Mother's Name (First, Middle, Maiden Surname) CARRIE FLORENCE ZERCHER	
19a. Informant's Name/Relationship (Type, Print) PATRICIA SHAUBER / DAUGHTER			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2430 SUDLERSVILLE ROAD SUDLERSVILLE, MD 21668	
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) CHESAPEAKE CREMATION	Date 02/18/2012
21. Signature of Funeral Service Licensee 			20c. Location - City or Town, State STEVENSVILLE, MD	
22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWMAN FUNERAL HOME, P.A. 130 SPEER ROAD CHESTERTOWN, MARYLAND 21620			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Renal failure</i>	
			Approximate Interval Between Onset and Death <i>2 months</i>	
23b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			23d. Due to (or as a consequence of): <i>Arteriosclerosis</i>	
			23e. Due to (or as a consequence of): <i></i>	
			23f. Due to (or as a consequence of): <i></i>	
23g. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown	
23d. Date of delivery Month 0 Day 0 Year 0				
24. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of injury (Month, Day, Year) M	28b. Time of injury M
			28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier 	
29c. License number D 16439			29d. Date signed (Month, Day, Year) 2/15/12	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wayne D. Benjamin, M.D.			31. Date filed (Month, Day, Year) FEB 17 2012	
32. Registrar's Signature 				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07649

1 - For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Marie T. Tsucasas				2. Date of Death Month February Day 25 , Year 2012	3. Time of Death 6:10A. M			
	4a. Facility Name (if not institution, give street and number) Renaissance Gardens at Riderwood Village				4b. City, Town, or Location of Death Silver Spring		4c. County of Death Prince George's		
Funeral Director	5. Social Security Number 579-03-8062	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) 96 Yrs.	If Under 1 Year Months 0	If Under 24 Hrs. Hours 0	Min. 0	8. Date of Birth (Month, Day, Year) Sept. 7, 1915	9. Birthplace (State or Foreign Country) Washington, DC	
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State Maryland 10b. County Montgomery				10c. City, Town or Location Silver Spring			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 3112 Gracefield Road, PV#610				10f. Zip Code 20904		10g. Citizen of What Country? United States		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: White		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 1-4		Housewife		16b. Kind of Business Industry own home		
	17. Father's Name (First, Middle, Last) Michael Androulakis				18. Mother's Name (First, Middle, Maiden Surname) Florence Barnes				
	19a. Informant's Name/Relationship (Type, Print) Robert C. Merrell /son-in-law				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4083 Hardwoods Drive Orchard Lake, Michigan 48323				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Hillside Cemetery		Date 3/1/2012	20c. Location - City or Town, State Rutherford, New Jersey			
	21. Signature of Funeral Service Licensee Donald V. Borgwardt				22. Name and Address of Facility Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705				
Physician/ Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metastatic Abdominal Carcinoma							Approximate Interval Between Onset and Death 3 months	
	23b. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
	<p>a. Due to (or as a consequence of): Metastatic Abdominal Carcinoma</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year				
Medical Certificate: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
					24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOD		26. Place of Death (Check only one) 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred			
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
	29b. Signature and title of certifier Mark Parkhurst, M.D.		29c. License number D24093		29d. Date signed (Month, Day, Year) February 27, 2012				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mark Parkhurst, M.D. 3110 Gracefield Road Silver Spring, Maryland 20904								
State Registrar	31. Date filed (Month, Day, Year) MAR 12 2012		32. Registrar's Signature Leanne J. Pailes						

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

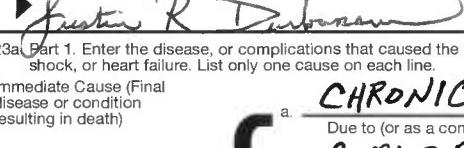
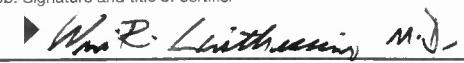
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07650

1 - For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Robert Daniel Willet					2. Date of Death Month <input type="text"/> Day <input type="text"/> Year <input type="text"/> February 18, 2012	3. Time of Death 12:45 p m
	4a. Facility Name (if not institution, give street and number) 2612 Tyrone Road			4b. City, Town, or Location of Death Westminster		4c. County of Death Carroll	
Funeral Director	5. Social Security Number 217-36-2523	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months <input type="text"/> Days <input type="text"/>	If Under 24 Hrs. Hours <input type="text"/> Min. <input type="text"/>	8. Date of Birth (Month, Day, Year) July 12, 1928	9. Birthplace (State or Foreign Country) Maryland
	10a. State Maryland			10b. County Carroll		10c. City, Town or Location Westminster	
To Be Completed by Funeral Director	10e. Street and Number 2612 Tyrone Road			10f. Zip Code 21158		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white
	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Farmer			16b. Kind of Business Industry Agriculture	
	17. Father's Name (First, Middle, Last) Daniel David Willet			18. Mother's Name (First, Middle, Maiden Surname) Dorothy Mae Starner			
	19a. Informant's Name/Relationship (Type, Print) Glen A. Willet, son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2628 Baumgardner Road, Westminster, MD 21158			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, cemetery or other place) Pleasant Valley Cemetery		Date 2/22/2012	20c. Location - City or Town, State Westminster, MD
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Myers-Durbaraw Funeral Home 136 E Baltimore St, Westminster, MD 21787			
Physician/ Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CHRONIC RENAL FAILURE Approximate Interval Between onset and Death 7 YEARS						
	23b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last COLORECTAL CARCINOMA Approximate Interval Between onset and Death 11 YEARS						
	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month <input type="checkbox"/> Day <input type="checkbox"/> Year			
Medical Certificate: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						
	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown						
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes <input type="checkbox"/> No			
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
	29b. Signature and title of certifier 			29c. License number J-0014317		29d. Date signed (Month, Day, Year) FEB. 20, 2012	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLIAM R. LINTHICUM, M.D., ONE KING DRIVE, TANDEMWOOD, MD 21787						
	31. Date filed (Month, Day, Year) FEB 23 2012		32. Registrar's Signature 				

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

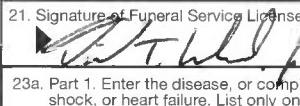
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07651

1 - For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Richard James Whitaker							2. Date of Death Month 02	Day 25	Year 2012	3. Time of Death 6:00 A M
	4a. Facility Name (if not institution, give street and number) 13 Tad Caster Circle				4b. City, Town, or Location of Death Waldorf			4c. County of Death Charles			
Funeral Director	5. Social Security Number 512-26-4847 Usual Residence of Decedent		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 78 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) 10-29-1933	9. Birthplace (State or Foreign Country) Kansas			
	10a. State Maryland	10b. County Charles	10c. City, Town or Location Waldorf				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
To Be Completed by Funeral Director	10e. Street and Number 6605 Cougar Court				10f. Zip Code 20603			10g. Citizen of What Country? United States			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Data Processor		16b. Kind of Business/Industry Internal Revenue Service						
	17. Father's Name (First, Middle, Last) Don Cooper Whitaker				18. Mother's Name (First, Middle, Maiden Surname) Nancy Elizabeth Thomas						
	19a. Informant's Name/Relationship (Type, Print) Patricia A. Whitaker/Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6605 Cougar Court Waldorf, Maryland 20603		Date 03-02-2012			20c. Location - City or Town, State Charlotte Hall, Maryland			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Brinsfield-Echols		20c. Location - City or Town, State Charlotte Hall, Maryland						
	21. Signature of Funeral Service License 		22. Name and Address of Facility Arehart-Echols Funeral Home, P.A. 211 St. Mary's Ave. Box 567 La Plata, MD 20646								
Physician/ Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death
	<p>a. Due to (or as a consequence of): MULTIPLE SCLEROSIS</p> <p>b. Due to (or as a consequence of): Advanced Multiple Sclerosis</p> <p>c. Due to (or as a consequence of):</p>										
Physician/ Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) _____ 9 <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year			
Medical Certificate: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred				
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
	29b. Signature and title of certifier 		29c. License number D20629		29d. Date signed (Month, Day, Year) 2/27/12						
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Granville Whitaker M.D. Waldorf, MD 20603										
	31. Date filed (Month, Day, Year) FEB 28 2012		32. Registrar's Signature 								

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

BA-10
State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2012 07652

Certificate of Death

Reg. No.

1- For
State
Registrar**Physician/
Medical
Examiner****Funeral
Director****To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**State
Registrar**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2012 07652

Certificate of Death

Reg. No.

1. Decedent's Name (First, Middle, Last) Elliott Pattison Wilson							2. Date of Death Month Day Year February 22 2012			3. Time of Death 11:44 p M
4a. Facility Name (if not institution, give street and number) 100 Radcliffe Drive				4b. City, Town, or Location of Death Cambridge			4c. County of Death Dorchester			
5. Social Security Number 214-07-7417		6. Sex M	7. Age (In yrs. last birthday) 97 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) Sept. 12, 1914	9. Birthplace (State or Foreign Country) Maryland			
10a. State MD	10b. County Dorchester	10c. City, Town or Location Cambridge			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
10e. Street and Number 3635 Linkwood Drive				10f. Zip Code 21613			10g. Citizen of What Country? USA			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: white			14. Race - American Indian, Black, White, etc. Specify: white			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) mail carrier			16b. Kind of Business/Industry U. S. Postal Service			
17. Father's Name (First, Middle, Last) John Robert Wilson				18. Mother's Name (First, Middle, Maiden Surname) Katherine Bell						
19a. Informant's Name/Relationship (Type, Print) Anne Pritchett daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 100 Radcliffe Drive, Cambridge, MD 21613						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) BFR				20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Cem			Date 2/29/12	20c. Location - City or Town, State Hurlock, MD		
21. Signature of Funeral Service Licensee BFR				22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 21613						
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Congestive Heart Failure									Approximate Interval Between Onset and Death	
<p>a. Due to (or as a consequence of): Congestive Heart Failure</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. _____</p>										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus									23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
									24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) daughter's home								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred				
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier Eugene Newmyer DO				29c. License number H51793			29d. Date signed (Month, Day, Year) 2/22/12			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eugene Newmyer DO 321 Dorchester Ave Suite 1 Cambridge MD 21613										
31. Date filed (Month, Day, Year) FEB 28 2012		32. Registrar's Signature Jean B. Park								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2012 07653

Certificate of Death

Reg. No.

1 - For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month Day Year	3. Time of Death
	Mark Anthony Warner				February 22 2012	1117 AM
Funeral Director	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death	
	Dorchester General Hospital		Cambridge		Dorchester	
To Be Completed by Funeral Director	5. Social Security Number	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. 54	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) July 18, 1957	9. Birthplace (State or Foreign Country) Maryland
	10a. State MD	10b. County Dorchester	10c. City, Town or Location Cambridge		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 2458 Cambridge Beltway	10f. Zip Code 21613	10g. Citizen of What Country?				
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: Black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) 12	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)	16b. Kind of Business Industry Entrepreneur	Construction			
17. Father's Name (First, Middle, Last) Norman Henry Warner, Sr.	18. Mother's Name (First, Middle, Maiden Surname) Sadie Copper					
19a. Informant's Name/Relationship (Type, Print) Vanessa Warner	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2458 Cambridge Beltway Cambridge, MD, 21613					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) McAshore Cremation Ctr., by McLean Crematorium, PA	Date 21/27/12	20c. Location - City or Town, State Cambridge, MD.			
21. Signature of Funeral Service Licensee ► Janelle C. Henry	22. Name and Address of Facility Henry Funeral Home, P.A. 510 Washington St, Cambridge, MD, 21613					
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	Cardiac arrest - Hyperensive cardiovascular disease Chronic obstructive pulmonary disease				Approximate Interval Between Onset and Death	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consequence of): Hyperensive cardiovascular disease	b. Due to (or as a consequence of): Chronic obstructive pulmonary disease	c. Due to (or as a consequence of):	d.		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown	
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide	28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
29b. Signature and title of certifier ► NORMAN TITANWY	29c. License number 1047924	29d. Date signed (Month, Day, Year) 2-22-2012				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NORMAN TITANWY 503 BYRN ST CAMBRIDGE MD 21613						
31. Date filed (Month, Day, Year) FEB 28 2012	32. Registrar's Signature J. A. [Signature]					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #30 per DVR G925 dk

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07654

1- For
State
Registrar**Physician/
Medical
Examiner**

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death Hour Minute AM PM
Ralph Aldus Weaver	February 29 2012	2:48 PM

4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Meritus Medical Center	Hagerstown	Washington

**Funeral
Director**

5. Social Security Number	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days Hours Min.	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) June 2, 1929	9. Birthplace (State or Foreign Country) Maryland
213-24-7826						

Usual Residence of Decedent

10a. State MD	10b. County Washington	10c. City, Town or Location Maugansville	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

10e. Street and Number P.O. Box 243, 14009 Weaver Ave.	10f. Zip Code 21767	10g. Citizen of What Country? U.S.A.

11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Maintenance	16b. Kind of Business/Industry Manufacturing

17. Father's Name (First, Middle, Last) Harry Weaver	18. Mother's Name (First, Middle, Maiden Surname) Oma Kendle

19a. Informant's Name/Relationship (Type, Print) Shirley A. Weaver / Spouse	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO Box 243, 14009 Weaver Ave., Maugansville, MD 21767

20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) Rest Haven Cemetery	Date 3/3/2012	20c. Location - City or Town, State Hagerstown, Maryland

21. Signature of Funeral Service Licensee ► Rhia M. Mitts	22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	Approximate Interval Between Onset and Death
a. <u>HYPOTENESIA</u> Due to (or as a consequence of): <u>PNEUMONIA</u> b. Due to (or as a consequence of): <u>ACUTE KIDNEY INJURY</u> c. Due to (or as a consequence of): <u>COPD</u> d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>CONGESTIVE HEART FAILURE</u>	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown

23f. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA	Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)

27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined	28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	29b. Signature and title of certifier Dr. Nicole Perrotte	29c. License number D0071486	29d. Date signed (Month, Day, Year) 02/29/12

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Nicole Perrotte, Meritus Medical Center, Hagerstown MD

31. Date filed (Month, Day, Year) MAR 12 2012	32. Registrar's Signature Janice S. Farrel
--	---

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit document.

Medical Certificate: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07655

1- For
State
RegistrarPhysician/
Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Stephen Ira Todd Whitacre

2. Date of Death

Month February Day 21, Year 2012

3. Time of Death

15:10 M

Funeral
Director

4a. Facility Name (if not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

5. Social Security Number

212-72-8550

6. Sex

1 X M 2 F

7. Age (in yrs. last birthday)

46

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

Month Day Year

Feb. 17, 1966

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Greenbelt

10d. Inside City Limits

X Yes 2 No

10e. Street and Number

7313 Morrison Drive

10f. Zip Code

20770

10g. Citizen of What Country?

United States

11. Marital Status

1 X Never Married 2 □ Married
3 □ Widowed 4 □ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 □ Yes 2 X No
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.
1 □ Yes 2 X No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Heavy Equipment Operator

16b. Kind of Business Industry

Construction

17. Father's Name (First, Middle, Last)

H. Stephen Whitacre

18. Mother's Name (First, Middle, Maiden Surname)

Marjorie Miller

19a. Informant's Name/Relationship (Type, Print)

Marjorie M. Whitacre -mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7313 Morrison Drive Greenbelt, Maryland 20770

20a. Method of Disposition

1 X Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify)

20b. Place of Disposition (Name of cemetery, graveyard or other place)

Baker United Methodist Church Cemetery

Date

2/26/2012

20c. Location - City or Town, State

Baker, West Virginia

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Donald V. Borgwardt Funeral Home, PA
4400 Powder Mill Road Beltsville, Maryland 20705

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use at the burial-transit once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death

a. Due to (or as a consequence of):

END STAGE LIVER DISEASE

ACUTE RENAL FAILURE

ACUTE PANCREATITIS

HEMOPHILIC ENCEPHALopathy

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 X No
9 □ Unknown23c. If yes, outcome of pregnancy
1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy
4 □ Pregnant at time of death 5 □ Other (Specify)
9 □ Unknown23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 □ Yes 2 □ No 3 □ Probably 4 X Unknown

25. Was case referred to medical examiner?

1 □ Yes 2 X No

Hospital:

1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA

Other:

4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)

27. Manner of Death

1 X Natural
2 □ Accident
3 □ Suicide
4 □ Homicide5 □ Pending Investigation
6 □ Could not be determined28a. Date of injury
(Month, Day, Year)

28b. Time of injury

28c. Injury at work?

1 □ Yes 2 □ No

28d. Describe how injury occurred

29a. Certifier
(Check only one)

2 □ Medical Examiner

3 □ Certifying Nurse Practitioner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D61307

29d. Date signed (Month, Day, Year)

02/21/12

30. Name and address of person who completed cause of death (Item 28a) (Type, Print)

Stephen Ira Todd Whitacre

7313 Morrison Drive

Greenbelt, MD 20770

31. Date filed (Month, Day, Year)

MAR 12 2012

32. Registrar's Signature

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07656

1 - For
State
RegisterPhysician/
Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Winley, Chester 2/22/2012 0545
Baltimore, Maryland 21215-0036

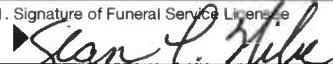
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/
Medical
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial transit

State
Registrar

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month 21 Day 22 Year 2012		3. Time of Death 0545 AM	
Chester Winley					
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death Rockville, MD		4c. County of Death Montgomery	
Shady Grove Adventist Hospital					
5. Social Security Number 578-12-0137		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F 88 Yrs.		7. Age in yrs. last birthday If Under 1 Year Months If Under 24 Hrs. Days Hours Min.	
10a. State MD		10b. County Montgomery		10c. City, Town or Location Montgomery Village	
10e. Street and Number 19301 Walkers Mill Rd.		10f. Zip Code 20886		10g. Citizen of What Country? U.S.A.	
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates. WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)		16b. Kind of Business Industry Shipping Clerk Printing	
17. Father's Name (First, Middle, Last) David Winley		18. Mother's Name (First, Middle, Maiden Surname) Adell Barnes			
19a. Informant's Name/Relationship (Type, Print) Janice M. Moore/Niece		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2059 Shadyside Way Germantown, MD 20874			
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Crematory		Date 03/01/2012	20c. Location - City or Town, State Brentwood, MD
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Rd. Brentwood, MD 20722			
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death	
23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year			
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	
		28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier 		29c. License number D 41162		29d. Date signed (Month, Day, Year) February 22, 2012	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Viny Gantim MD 19529 Doctor's Dr. Germantown, MD 20874					
31. Date filed (Month, Day, Year) FEB 28 2012		32. Registrar's Signature 			

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

2012 07657

1 - For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Andre' Williams					2. Date of Death Month Day Year February 18 2012	3. Time of Death 8:12 PM	
	4a. Facility Name (if not institution, give street and number) Doctor's Community Hospital					4b. City, Town, or Location of Death Lanham		4c. County of Death PG
Funeral Director	5. Social Security Number 577-90-9365	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 51 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Feb. 3, 1961	9. Birthplace (State or Foreign Country) DC	
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland	10b. County Prince George's	10c. City, Town or Location Greenbelt			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 7714 Hanover Parkway # 203		10f. Zip Code 20770			10g. Citizen of What Country? United States		
Physician/ Medical Examiner	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Black Specify:	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cook			16b. Kind of Business/Industry Government		
Medical Certificate: To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Otto Williams			18. Mother's Name (First, Middle, Maiden Surname) Joan Mason				
	19a. Informant's Name/Relationship (Type, Print) Ruth Williams - Wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7714 Hanover Parkway # 203 Greenbelt, Md. 20770				
Medical Certificate: To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill		Date Feb. 27, 2012	20c. Location - City or Town, State Suitland, Maryland		
	21. Signature of Funeral Service Licensee John T. Stewart		22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road NE Washington, DC 20019					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Anoxic Brain Injury								
a. Due to (or as a consequence of): Respiratory Failure								
b. Due to (or as a consequence of): Acute myocardial infarction								
c. Due to (or as a consequence of):								
d. Due to (or as a consequence of):								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. End stage renal disease								
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA		26. Place of Death (Check only one) Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number D65909						
29b. Signature and title of certifier Fasi Ahemu		29d. Date signed (Month, Day, Year) 01/23/12						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Fasi Ahemu 8118 Good Luck Road, Lanham, MD 20706								
31. Date filed (Month, Day, Year) FEB 27 2012		32. Registrar's Signature Fasi Ahemu						

WILLIAMS ANDRE

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07658

1 - For
State
Registrar

1. Decedent's Name (First, Middle, Last)

EILEEN HANNAGAN WALSH

2. Date of Death

Month Day Year
FEBRUARY 22 2012

3. Time of Death

22:14 M

Physician/
Medical
Examiner

4a. Facility Name (if not institution, give street and number)

MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

EASTON

4c. County of Death

TALBOT

Funeral
Director

5. Social Security Number

034-14-1876

6. Sex

M F

7. Age (In yrs. last birthday)

84

Yrs.

If Under 1 Year

Months Days Hours Min.

8. Date of Birth

Month Day Year
03/29/1927

9. Birthplace (State or Foreign
Country)

MASSACHUSETTS

To Be Completed by Funeral Director

Usual Residence of Decedent
10a. State MD 10b. County QUEEN ANNE'S 10c. City, Town or Location GRASONVILLE 10d. Inside City Limits
 Yes No

Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

10e. Street and Number

9 FAIRWAY ISLAND

10f. Zip Code
21638

10g. Citizen of What Country?
UNITED STATES

11. Marital Status

Never Married Married
 Widowed Divorced

12. Was Decedent Ever in U.S. Armed Forces?

Yes No
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No)
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Yes No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business Industry

OWN HOME

17. Father's Name (First, Middle, Last)

JOSEPH HANNAGAN

18. Mother's Name (First, Middle, Maiden Surname)

ROSE SUDA

19a. Informant's Name/Relationship (Type, Print)

THOMAS M. WALSH / SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

113 RIVER RUN, QUEENSTOWN, MD 21658

20a. Method of Disposition

Burial Cremation Removal from State
 Donation Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ST. PETER'S CATHOLIC CEMETERY

Date

02/28/2012

20c. Location - City or Town, State

QUEENSTOWN, MD

21. Signature of Funeral Service Licensee

► *Chl M. Helfer*

22. Name and Address of Facility

FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.
106 SHAMROCK ROAD, CHESTER, MD 21619

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death
a. MYOCARDIAL INFARCTION Due to (or as a consequence of):		
b. Due to (or as a consequence of):		
c. Due to (or as a consequence of):		
d. Due to (or as a consequence of):		

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
 Yes No
 Unknown

23c. If yes, outcome of pregnancy

Live Birth Fetal death Ectopic pregnancy
 Pregnant at time of death Other (Specify)
 Unknown

23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?
 Yes No Probably Unknown

25. Was case referred to medical examiner?

Yes No

Hospital:

Inpatient ER/Outpatient DCA

26. Place of Death (Check only one)

Nursing Home Residence Other (Specify)

27. Manner of Death

Natural Pending Investigation
 Accident Could not be determined
 Suicide Determined
 Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

Yes No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

► *J Schmidlein*

29c. License number

D0030741

29d. Date signed (Month, Day, Year)

2/23/2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JEFFREY SCHMIDLEIN 844 RITCHIE HWY., SUITE 206, SEVERNA PARK, MD 21146

31. Date filed (Month, Day, Year)

FEB 24 2012

32. Registrar's Signature

► *Laura B. Jones*

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

within 24 hours after death.
Completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

once.

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07659

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Robert Waters				2. Date of Death Month Day Year February, 19, 2012 8:03 AM		3. Time of Death	
	4a. Facility Name (If not institution, give street and number) Aurora Senior Living of Manokin		4b. City, Town, or Location of Death Princess Anne		4c. County of Death Somerset			
Funeral Director	5. Social Security Number 212-76-0329	6. Sex M	7. Age (In yrs. last birthday) 92 Yrs.	If Under 1 Year Months Days Hours Min.	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Dec. 14, 1919	9. Birthplace (State or Foreign Country) Maryland	
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State Maryland 10b. County Somerset 10c. City, Town or Location Princess Anne				10d. Inside City Limits X Yes 2 No			
	10e. Street and Number 119 74 Edgehill Terrace		10f. Zip Code 21853		10g. Citizen of What Country? U.S.A.			
	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:		14. Race - American Indian, Black, White, etc. Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) None		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Never Worked		16b. Kind of Business/Industry Never Worked			
	17. Father's Name (First, Middle, Last) William Waters				18. Mother's Name (First, Middle, Maiden Surname) Sarah Waters			
	19a. Informant's Name/Relationship (Type, Print) Vernel Coffman - Cousin		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25 A West Chesapeake Ave, Crisfield, MD 21817					
	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Asbury U.M.C. Cemetery		Date 2/25/12	20c. Location - City or Town, State Crisfield, MD		
	21. Signature of Funeral Service Licensee At E. Ward		22. Name and Address of Facility Anthony E. Ward F. H. 30639 Hampden Ave, Princess Anne, MD 21853					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ASCVD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last DEMENTIA Approximate Interval Between Onset and Death 5 years 10 years.							
Medical Certification: To Be Completed by Physician/Medical Examiner	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)		23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown							
	24a. Was an autopsy performed? 1 Yes 2 No		24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No					
	25. Was case referred to medical examiner? 1 Yes 2 No		26. Place of Death Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)					
	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occurred	
	5 Pending investigation 6 Could not be determined		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier Lisha Nath		29c. License number DO51359		29d. Date signed (Month, Day, Year) February 22nd 2012			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. USHA NATESAN 1415 - S. DIVISION ST, SALISBURY MD 21804							
State Registrar	31. Date filed (Month, Day, Year) FEB 24 2012	32. Registrar's Signature Lenna B. Spence						

Baltimore, Maryland 21215-0036
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07660

1 - For
State
Registrar

Physician/
Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician/
Medical
Examiner

Medical Certificate To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death 2341 PM
Ralph Junior Ward		February 22 2012		
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
Union Hospital		Elkton		Cecil
5. Social Security Number 235-52-3736		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months Days Hours Min. If Yes, Give Year or Dates.
8. Date of Birth (Month, Day, Year) March 16, 1934		9. Birthplace (State or Foreign Country) West Virginia		
Usual Residence of Decedent		10a. State Maryland		10b. County Cecil
10c. City, Town or Location Elkton				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number 121 Whitmore Drive		10f. Zip Code 21921		10g. Citizen of What Country? United States
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
				14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Supervisor		16b. Kind of Business Industry Paper Mill
17. Father's Name (First, Middle, Last) Friend Ward		18. Mother's Name (First, Middle, Maiden Surname) Rena Jones		
19a. Informant's Name/Relationship (Type, Print) Patricia Ward/Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 121 Whitmore Drive, Elkton, MD 21921		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) Friend Ward Cemetery		20b. Place of Disposition (Name of cemetery, crematory or other place) Friend Ward Cemetery		Date March 1, 2012
				20c. Location - City or Town, State Hix, WV
21. Signature of Funeral Service Licensee <i>Patricia Ward/Eusman</i>		22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, MD 21921		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		Approximate Interval Between Onset and Death
		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		
23d. Date of delivery Month Day Year				
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of injury M
		28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <i>D72332</i>		29d. Date signed (Month, Day, Year) <i>2/23/12</i>
29b. Signature and title of certifier <i>Haddadin Yazan MD</i>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>DR. YAZAN HADDADIN 106 Bow St. ELKTON, MD 21921</i>				
31. Date filed (Month, Day, Year) <i>MAR 09 2012</i>		32. Registrar's Signature <i>Janet S. Parker</i>		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2012 07661

Reg. No.

1- For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Shirley Mae Ahearn				2. Date of Death Month MARCH Day 8 , 2012 Year	3. Time of Death 10:16A M		
	4a. Facility Name (if not institution, give street and number) SAINT JOSEPH MEDICAL CENTER		4b. City, Town, or Location of Death TOWSON		4c. County of Death BALTIMORE			
Funeral Director	5. Social Security Number 039-16-0747	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) JAN 23, 1929	9. Birthplace (State or Foreign Country) Rhode Island	
	Usual Residence of Decedent MD Baltimore		10a. State 10b. County 10c. City, Town or Location Timonium				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number 2525 Pot Spring Road, #L317			10f. Zip Code 21093		10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Homemaker		16b. Kind of Business/Industry Own Home			
	17. Father's Name (First, Middle, Last) Thomas Leo Jackson			18. Mother's Name (First, Middle, Maiden Surname) Beatrice Kent				
	19a. Informant's Name/Relationship (Type, Print) Eugene F. Ahearn, husband			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2525 Pot Spring Rd., #L317 Timonium, MD 21093				
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc.		Date 03/09/12	20c. Location - City or Town, State Baltimore, MD		
	21. Signature of Funeral Service Licensee George MacNabb		22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228					
Physician/ Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) INTRACRANIAL HEMORRHAGE						Approximate Interval Between Onset and Death 3 DAYS	
	a. Due to (or as a consequence of): PNEUMONIA						5 DAYS	
	b. Due to (or as a consequence of): RESPIRATORY FAILURE						5 DAYS	
	c. Due to (or as a consequence of):							
	d.							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
Medical Certificate: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
							25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA						26. Place of Death (Check only one) Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one						29d. Date signed (Month, Day, Year) 3-8-12	
	29b. Signature and title of certifier Linda Adler MD						29c. License number D59711	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LINDA ADLER, M.D. 7601 OSLER DRIVE TOWSON, MD 21204							
	31. Date filed (Month, Day, Year) MAR 13 2012		32. Registrar's Signature Linda J. Parker					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07662

1- For
State
Registrar

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) CARRIE A ARNwine						2. Date of Death Month March Day 5 Year 2012		3. Time of Death 10:15PM			
Funeral Director		4a. Facility Name (if not institution, give street and number) 906 N. Warwick Ave			4b. City, Town, or Location of Death Baltimore			4c. County of Death N/A					
To Be Completed by Funeral Director		5. Social Security Number 214-80-1454		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 53 Yrs.	If Under 1 Year Months 0 Days 0		If Under 24 Hrs. Hours 0 Min. 0		8. Date of Birth (Month, Day, Year) Dec 12, 1958			
To Be Completed by Physician/Medical Examiner		9. Birthplace (State or Foreign Country) MD								10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner		10a. State MD			10b. County N/A			10c. City, Town or Location Baltimore					
To Be Completed by Physician/Medical Examiner		10e. Street and Number 906 N. Warwick Ave			10f. Zip Code 21216			10g. Citizen of What Country? USA					
To Be Completed by Physician/Medical Examiner		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates. 1960-1965		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Black			14. Race - American Indian, Black, White, etc. Specify: Black				
To Be Completed by Physician/Medical Examiner		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Community Health Worker			16b. Kind of Business Industry Healthcare					
To Be Completed by Physician/Medical Examiner		17. Father's Name (First, Middle, Last) Floyd Arnwine			18. Mother's Name (First, Middle, Maiden Surname) Julian Small			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 906 N Warwick Ave, Baltimore, MD					
To Be Completed by Physician/Medical Examiner		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Maryland National Cemetery		20b. Place of Disposition (Name of cemetery/crematory or other place) Maryland National Cemetery		Date 3/12/2012		20c. Location - City or Town, State Laurel, MD					
To Be Completed by Physician/Medical Examiner		21. Signature of Funeral Service License Funeral Director		22. Name and Address of Facility Howell Funeral Home 4600 Liberty Heights Ave, Baltimore, MD									
To Be Completed by Physician/Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) metastatic breast cancer						Approximate Interval Between Onset and Death 7 months					
To Be Completed by Physician/Medical Examiner		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last {											
To Be Completed by Physician/Medical Examiner		23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month 0 Day 0 Year 0						
To Be Completed by Physician/Medical Examiner		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
To Be Completed by Physician/Medical Examiner		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) Residence			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year) March 12, 2012		28b. Time of injury M 12 Yes 0 No		28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred			
To Be Completed by Physician/Medical Examiner		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner		29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
To Be Completed by Physician/Medical Examiner		29b. Signature and title of certifier Rosie Connolly			29c. License number D71526			29d. Date signed (Month, Day, Year) March 6, 2012					
To Be Completed by Physician/Medical Examiner		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROISIN CONNOLLY, MD. 401 N. Broadway, Rm 1363, Baltimore, MD 21231											
State Registrar		31. Date filed (Month, Day, Year) MAR 13 2012		32. Registrar's Signature A. J. [Signature]									

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07663

1- For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Hilda Celeste Abernathy							2. Date of Death Month March Day 11 , Year 2012	3. Time of Death 12:10a^M		
	4a. Facility Name (if not institution, give street and number) Dove House			4b. City, Town, or Location of Death Westminster			4c. County of Death Carroll				
Funeral Director	5. Social Security Number 214-12-7171	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 91 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) 10/10/1920	9. Birthplace (State or Foreign Country) MD				
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State MD 10b. County Carroll 10c. City, Town or Location Hampstead							10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	10e. Street and Number 2411 Fairway Oaks Court			10f. Zip Code 21074			10g. Citizen of What Country? USA				
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) 9			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) homemaker			16b. Kind of Business Industry own home				
	17. Father's Name (First, Middle, Last) John Henry Latleif				18. Mother's Name (First, Middle, Maiden Surname) Esther Brown						
	19a. Informant's Name/Relationship (Type, Print) Donald I. Abernathy, son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2411 Fairway Oaks Court, Hampstead, MD 21074							
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Lake View Memorial			Date 3/15/2012	20c. Location - City or Town, State Sykesville, MD			
	21. Signature of Funeral Service Licensee ► Shanda L Lemmer			22. Name and Address of Facility Eline Funeral Home 934 S. Main St., Hampstead, MD 21074							
Physician/ Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) FAILURE TO THRIVE								Approximate Interval Between Onset and Death		
	a. Due to (or as a consequence of): C. Diff colitis Diarrhea										
	b. Due to (or as a consequence of): Sepsis										
	c. Due to (or as a consequence of):										
	d. Due to (or as a consequence of):										
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year			
Medical Certificate: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
									24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) DOVE HOUSE HOSPICE								
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred ► Dove House Hospice				
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	29a. Certifier <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number D-0054218						29d. Date signed (Month, Day, Year) 03-12-2012		
	29b. Signature and title of certifier ► RBC Chen M.D.										
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. RAMAN B-KANTHA, 349 Malalmaline, Westminster MD 21157										
State Registrar	31. Date filed (Month, Day, Year) MAR 13 2012		32. Registrar's Signature Leanne J. Farley								

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial transit.

Medical Certificate: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07664

1 - For
State
Registrar

**Physician/
Medical
Examiner**

**Funeral
Director**

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death
<i>Irene Waltraud Arkebauer</i>		March 7, 2012		1:20 PM
4a. Facility Name (if not institution, give street and number) Medstar Montgomery Medical Ctr.		4b. City, Town, or Location of Death Olney		4c. County of Death Montgomery
5. Social Security Number 578-42-6231		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months Days Hours Min.
Usual Residence of Decedent MD Montgomery		10c. City, Town or Location Rockville		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
10e. Street and Number 4401 Chestnut Lane		10f. Zip Code 20850		10g. Citizen of What Country? United States
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 4 Translator		16b. Kind of Business/Industry Health Organization
17. Father's Name (First, Middle, Last) Edwin Alexander Langenstrassen		18. Mother's Name (First, Middle, Maiden Surname) Margarethe Bertha Schubert		
19a. Informant's Name/Relationship (Type, Print) Karen E. Hill / Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18303 Leedstown Way, Olney, MD 20832		
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory		Date 03/10/2012
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD 20910		20c. Location - City or Town, State Beltsville, MD
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death Unknown
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		a. Due to (or as a consequence of): Heart Failure		
		b. Due to (or as a consequence of): Aortic Stenosis		
		c. Due to (or as a consequence of):		
		d. Due to (or as a consequence of):		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number D 61624		29d. Date signed (Month, Day, Year) March 7, 2012
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Yuanjue Louann Zhang M.D. 18101 Prince Phillip Dr Olney MD 20852		31. Date filed (Month, Day, Year) MAR 13 2012		32. Registrar's Signature 

**State
Registrar**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2012 07665

Reg. No.

1 For
State
Registrar

Physician/
Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Division of Vital Records, P.O. Box 68700

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

10 ✓

Medical Certificate: To Be Completed by Physician/Medical Examiner

State
Registrar

1. Decedent's Name (First, Middle, Last) Marylee Odessa Amoss				2. Date of Death Month March Day 11 , Year 2012	3. Time of Death 6:00 PM		
4a. Facility Name (if not institution, give street and number) 801 Stiles Court				4b. City, Town, or Location of Death Joppa			
5. Social Security Number 218-12-7073		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) Aug. 23, 1921	9. Birthplace (State or Foreign Country) Maryland
Usual Residence of Decedent 10a. State Maryland 10b. County Harford				10c. City, Town or Location Joppa			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number 801 Stiles Court				10f. Zip Code 21085		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Senior Central Office Clerk		16b. Kind of Business Industry Utility Company	
17. Father's Name (First, Middle, Last) Saville Wilson Miller				18. Mother's Name (First, Middle, Maiden Surname) Mary Cornelia Tucker			
19a. Informant's Name/Relationship (Type, Print) Barbara N. Wolfe / Niece				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 801 Stiles Ct., Joppa, Maryland 21085			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>[Signature]</i>				20b. Place of Disposition (Name of cemetery, crematory or other place) Moreland Memorial Pk.		Date 3-15-12	20c. Location - City or Town, State Baltimore, Maryland
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009			
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Ischemic Cardiomyopathy Approximate Interval Between Onset and Death 3 months							
b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier <i>[Signature]</i> M.D.				29c. License number D35012		29d. Date signed (Month, Day, Year) 03/12/2012	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. Kevin Lynch, MD 615 W. Marlboro Rd. Bel Air, Md. 21014							
31. Date filed (Month, Day, Year) MAR 13 2012		32. Registrar's Signature <i>[Signature]</i>					

ORIGINAL

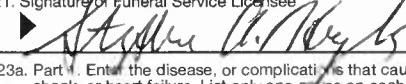
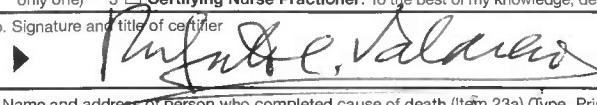
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07666

1 - For State Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Helen Jean Ails				2. Date of Death Month March	Day 9	Year 2012	3. Time of Death 9:45 A M		
Funeral Director	4a. Facility Name (if not institution, give street and number) 426 Larkspur Drive			4b. City, Town, or Location of Death Joppa		4c. County of Death Harford				
To Be Completed by Funeral Director	5. Social Security Number 361-20-3035		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) 83 Yrs.	If Under 1 Year Months 0	If Under 24 Hrs. Days 0	Hours 0	Min. 0		
To Be Completed by Physician/Medical Examiner	Usual Residence of Decedent 10a. State Maryland				10b. County Harford					
Physician/ Medical Examiner	10c. City, Town or Location Joppa				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
Medical Certificate: To Be Completed by Physician/Medical Examiner	10e. Street and Number 426 Larkspur Drive				10f. Zip Code 21085		10g. Citizen of What Country? USA			
Medical Certificate: To Be Completed by Physician/Medical Examiner	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. Specify: White		
Medical Certificate: To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) 4			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Registered Nurse			16b. Kind of Business Industry Healthcare			
Medical Certificate: To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Robert Sparrow Johnston				18. Mother's Name (First, Middle, Maiden Surname) Lillian (unk) Pickering					
Medical Certificate: To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Roscoe Cleveland Ails / Spouse			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 426 Larkspur Drive, Joppa, Maryland 21085						
Medical Certificate: To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Rose Hill Svcs. LLC			Date 3/12/2012	20c. Location - City or Town, State Bel Air, Maryland		
Medical Certificate: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009					
Medical Certificate: To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. DEMENTIA								Approximate Interval Between Onset and Death OVER 5 YEARS	
Medical Certificate: To Be Completed by Physician/Medical Examiner	a. Due to (or as a consequence of): {									
Medical Certificate: To Be Completed by Physician/Medical Examiner	b. Due to (or as a consequence of): 									
Medical Certificate: To Be Completed by Physician/Medical Examiner	c. Due to (or as a consequence of): 									
Medical Certificate: To Be Completed by Physician/Medical Examiner	d. Due to (or as a consequence of): 									
Medical Certificate: To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown						23d. Date of delivery Month Day Year	
Medical Certificate: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
Medical Certificate: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
Medical Certificate: To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
Medical Certificate: To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)	
Medical Certificate: To Be Completed by Physician/Medical Examiner	29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29c. License number DQ916389					
Medical Certificate: To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier 								29d. Date signed (Month, Day, Year) MARCH 8, 2012	
Medical Certificate: To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PERPECTO L. VILLARDO, M.D. 1716 HARFORD ROAD SUITE 105 FALLSTON MD 21047								31. Date filed (Month, Day, Year) MAR 13 2012	
Medical Certificate: To Be Completed by Physician/Medical Examiner	32. Registrar's Signature 								33. Date signed (Month, Day, Year)	

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 07667

1 - For
State
Registrar

Certificate of Death

Reg. No.

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Mae E. Barrett						2. Date of Death Month March Day 11 , Year 2012	3. Time of Death 11:16 A M
	4a. Facility Name (if not institution, give street and number) Anne Arundel Medical Center			4b. City, Town, or Location of Death Annapolis			4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 144-18-9848	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 89 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) April 20, 1922	9. Birthplace (State or Foreign Country) New Jersey	
	10a. State MD			10b. County Anne Arundel	10c. City, Town or Location Rose Haven			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
To Be Completed by Funeral Director	10e. Street and Number 658 Emmett Place				10f. Zip Code 20714		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. Specify: White
To Be Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 2 Homemaker			16b. Kind of Business/Industry Own Home	
	17. Father's Name (First, Middle, Last) Vincent Polidori			18. Mother's Name (First, Middle, Maiden Surname) Frieda Witrock				
Physician/ Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Jill E. Barrett, daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 658 Emmett Place Rose Haven, Maryland 20714				
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc.			Date 03/12/12	
Medical Certificate: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee George MacNabb			22. Name and Address of Facility Cremation Society of MD, Inc.				
				22. Name and Address of Facility 299 Frederick Road Baltimore, MD 21228				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
Immediate Cause (Final disease or condition resulting in death)								
23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
23c. Approximate Interval Between Onset and Death								
23d. Date of delivery								
23e. Did tobacco use contribute to the cause of death?								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined								
28a. Date of injury (Month, Day, Year) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28b. Time of injury M 28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred								
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier Howard Young, M.D.								
29c. License number P00058297								
29d. Date signed (Month, Day, Year) 3/11/2012								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Howard Young, M.D. 2001 Medical Parkway Annapolis, Maryland 21401								
31. Date filed (Month, Day, Year) MAR 13 2012		32. Registrar's Signature James J. Gove						

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07668

1- For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Fern Rebecca Barner</i>					2. Date of Death Month: March Day: 8 Year: 2012	3. Time of Death 6:10 A M
	4a. Facility Name (if not institution, give street and number) <i>Genesis Eldercare Severna Park</i>		4b. City, Town, or Location of Death <i>Severna Park</i>			4c. County of Death <i>Anne Arundel</i>	
Funeral Director	5. Social Security Number <i>160-05-8301</i>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>92 Yrs.</i>	If Under 1 Year Months <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12 <input type="checkbox"/> 13 <input type="checkbox"/> 14 <input type="checkbox"/> 15 <input type="checkbox"/> 16 <input type="checkbox"/> 17 <input type="checkbox"/> 18 <input type="checkbox"/> 19 <input type="checkbox"/> 20 <input type="checkbox"/> 21 <input type="checkbox"/> 22 <input type="checkbox"/> 23 <input type="checkbox"/> 24 <input type="checkbox"/> 25 <input type="checkbox"/> 26 <input type="checkbox"/> 27 <input type="checkbox"/> 28 <input type="checkbox"/> 29 <input type="checkbox"/> 30 <input type="checkbox"/> 31 <input type="checkbox"/> 32 <input type="checkbox"/> 33 <input 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	To Be Completed by Funeral Director		10e. Street and Number <i>310 Genesis Way</i>		10f. Zip Code <i>21146</i>	10g. Citizen of What Country? <i>USA</i>	
To Be Completed by Physician/Medical Examiner		19a. Informant's Name/Relationship (Type, Print) <i>Anne E. Veach, daughter</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>81 Road End Lane Severna Park, Maryland 21146</i>			
		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>9</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Metro Crematory, Inc.</i>		Date <i>03/09/12</i>	
		21. Signature of Funeral Service Licensee <i>George MacNabb</i>		22. Name and Address of Facility <i>Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228</i>			
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Hypertensive Cardiovascular disease</i>		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <i>9</i>		Approximate Interval Between Onset and Death <i>years</i>	
		23d. Date of delivery Month Day Year <i>Month Day Year</i>		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <i>Nursing Home</i>			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07669

1- For
State
RegistrarPhysician/
Medical
ExaminerFuneral
Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death
HAZEL E. Burlock		(3 7 2012)		9:33 A M
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
102 N. Crain Hwy Apt. 945		Glen Burnie		Anne Arundel
5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) 87 Yrs.	8. Date of Birth (Month, Day, Year) 4-24-1924
9. Birthplace (State or Foreign Country) MD		10. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Usual Residence of Decedent				
10a. State MD	10b. County Anne Arundel	10c. City, Town or Location Glen Burnie		
10e. Street and Number 102 N. Crain Hwy Apt. 945		10f. Zip Code 21041		10g. Citizen of What Country? USA
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Black		14. Race - American Indian, Black, White, etc.
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Kitchen Aide		16b. Kind of Business Industry Department of Aging
17. Father's Name (First, Middle, Last) James A. Thomas, Sr.		18. Mother's Name (First, Middle, Maiden Surname) Alethea Ingram		
19a. Informant's Name/Relationship (Type, Print) Dr. Julius Zant - Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3772 Old Post Rd. Salisbury, MD 21804		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery	Date 3/12/2012	20c. Location - City or Town, State Baltimore, MD
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility March F/H-East 1101 E. North Ave. Baltimore, MD 21202		
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death		
<p>a. Arterio Sclerotic Cardiovascular Disease Due to (or as a consequence of): Coronary artery disease</p> <p>b. Due to (or as a consequence of): Hypertension</p> <p>c. Due to (or as a consequence of): Diabetes</p>				
23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dyslipidemia		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number 042820		
29b. Signature and title of Certifier 		29d. Date signed (Month, Day, Year) 03/12/2012		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Christopher deBonzi 3708 Mountain Rd Pasadena MD 21112				
31. Date filed (Month, Day, Year) MAR 13 2012		32. Registrar's Signature Leanne B. Parker		

State
Registrar

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 26a show any injury or other traumatic event, the Medical Examiner must be notified once.

Physician/
Medical
Examiner

Funeral
Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

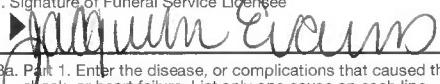
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07670

1 - For
State
Registrar

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) John Bearman						2. Date of Death Month March Day 8 Year 2012			3. Time of Death 5:09 PM						
Funeral Director		4a. Facility Name (if not institution, give street and number) 508 Holden Road			4b. City, Town, or Location of Death Towson			4c. County of Death Baltimore									
		5. Social Security Number 216-24-7496		6. Sex 1 X M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months 0	If Under 24 Hrs. Days 0	8. Date of Birth (Month, Day, Year) March 13, 1927	9. Birthplace (State or Foreign Country) Baltimore, MD								
		10a. State MD		10b. County Baltimore		10c. City, Town or Location Towson			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 X No								
		10e. Street and Number 508 Holden Road				10f. Zip Code 21286			10g. Citizen of What Country? United States								
		11. Marital Status 1 <input type="checkbox"/> Never Married 2 X Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates. WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 X No Specify: White			14. Race - American Indian, Black, White, etc. Specify: White								
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mechanic			16b. Kind of Business/Industry Railroad									
		17. Father's Name (First, Middle, Last) Rufus Bearman				18. Mother's Name (First, Middle, Maiden Surname) Anna Wheeler											
		19a. Informant's Name/Relationship (Type, Print) Ann Bearman- Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 508 Holden Road Towson, Maryland 21286											
		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 X Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Evans Funeral Chapel- Bel Air			20c. Location - City or Town, State Forest Hill, Maryland									
		21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Evans Funeral Chapel & Cremation Services 8800 Harford Rd. Parkville, MD 21234											
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Aortic valve stenosis						Approximate Interval Between Onset and Death 27 years									
		<p>a. Due to (or as a consequence of): Aortic valve stenosis</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>															
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)			23d. Date of delivery Month Day Year									
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Obstructive sleep apnea						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 X No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 X No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 X Residence 6 <input type="checkbox"/> Other (Specify)			24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 X No			24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
		27. Manner of Death 1 X Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide			28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
		29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29c. License number D26534			29d. Date signed (Month, Day, Year) 03/09/2012									
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Marc Schleifer MD 120 South Perry Dr. Suite 105 Towson MD 21204															
		31. Date filled (Month and Year) MAR 13 2012			32. Registered by [Signature]												

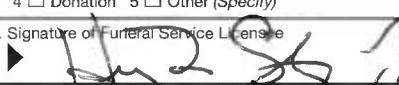
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07671

1 - For State Registrar		2. Date of Death Month March Day 12 Year 2012				3. Time of Death 08:00 AM		
Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Deborah Ann Bell				4a. Facility Name (if not institution, give street and number) 232 12th Street			
					4b. City, Town, or Location of Death Pasadena			
Funeral Director	5. Social Security Number 214-92-1422		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 48 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) July 08 1963	9. Birthplace (State or Foreign Country) MD
Usual Residence of Decedent		10a. State Maryland	10b. County Anne Arundel	10c. City, Town or Location Pasadena				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
10e. Street and Number 232 12th Street		10f. Zip Code 21122				10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) 11		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Homemaker		16b. Kind of Business Industry Household				
17. Father's Name (First, Middle, Last) Robert Hittel				18. Mother's Name (First, Middle, Maiden Surname) Anita Zamencki				
19a. Informant's Name/Relationship (Type, Print) Craig Bell (spouse)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 232 12th Street, Pasadena, MD 21122				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory Inc.			Date March 19	20c. Location - City or Town, State Baltimore, Maryland		
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122						
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)						
a. Due to (or as a consequence of): Breast Cancer		Approximate Interval Between Onset and Death 3 yrs						
b. Due to (or as a consequence of):								
c. Due to (or as a consequence of):								
d. Due to (or as a consequence of):								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 		29c. License number D31322		29d. Date signed (Month, Day, Year) 3/12/12				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DEEPAK GARG 4304 MTN. Rd PASADENA, MD 21122								
31. Date filed (Month, Day, Year) MAR 13 2012		32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07672

1 - For
State
Registrar

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) John Allen Bowman, Jr.				2. Date of Death Month 3 Day 9 Year 2012	3. Time of Death 8:00 AM		
Funeral Director		4a. Facility Name (if not institution, give street and number) FRANKLIN Square Hospital		4b. City, Town, or Location of Death Rosedale		4c. County of Death Baltimore			
To Be Completed by Funeral Director		5. Social Security Number 212-20-7123	6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months Days Hours Min. 	8. Date of Birth (Month, Day, Year) 01/08/1924	9. Birthplace (State or Foreign Country) MD		
		Usual Residence of Decedent MD Baltimore		10a. State MD		10b. County Baltimore		10c. City, Town or Location Essex	10d. Inside City Limits 1 Yes 2 No
		10e. Street and Number 1813 Old Eastern Avenue #212				10f. Zip Code 21221		10g. Citizen of What Country? U.S.A.	
		11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1943-46		13. Was Decedent of Hispanic Origin? (Specify Yes or No) 1 Yes 2 No Specify:		14. Race - American Indian, Black, White, etc. White	
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Steel Mill Supervisor		16b. Kind of Business/Industry Bethlehem Steel			
		17. Father's Name (First, Middle, Last) John Allen				18. Mother's Name (First, Middle, Maiden Surname) Bowman, Sr. Ruby Lupton			
		19a. Informant's Name/Relationship (Type, Print) Douglas S. Bowman, Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1814 Walnut Avenue, Dundalk, MD 21222			
		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Memorial		Date 03/14/2012	20c. Location - City or Town, State Timonium, MD		
		21. Signature of Funeral Service Licensee Alexandria Blair		22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road, Baltimore, MD 21214					
Physician/ Medical Examiner		<p>23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.</p> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. Sepsis Due to (or as a consequence of):</p> <p>b. MRSA Bacteremia Due to (or as a consequence of):</p> <p>c. cerebrovascular accident Due to (or as a consequence of):</p> <p>d. carotid artery stenosis Due to (or as a consequence of):</p> <p>Approximate Interval Between Onset and Death > 4 days</p>							
To Be Completed by Physician/Medical Examiner		<p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> <p>{</p>							
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown		23d. Date of delivery Month Day Year			
		<p>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</p> <p>Benign prostatic hyperplasia, u/I</p> <p>Dementia, hyperlipidemia</p> <p>23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown</p>							
		25. Was case referred to medical examiner? 1 Yes 2 No		26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)		23f. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown			
		27. Manner of Death 1 Natural 5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 Yes 2 No	28d. Describe how injury occurred		
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
		29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number D0065641		29d. Date signed (Month, Day, Year) 3-9-2012			
		29b. Signature and title of certifier Kamal Bangoria, M.D.		29c. License number D0065641		29d. Date signed (Month, Day, Year) 3-9-2012			
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR Kamal Bangoria 2314 E Joppa Rd Suite 1 Parkville Md 21234		31. Date filed (Month, Day, Year) MAR 13 2012		32. Registrar's Signature S. Sparks			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#30perDVR, G925, 3/13/2012, WS

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07673

1 - For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

TOMMY L BAIZE

2. Date of Death

Month

Day

Year

3. Time of Death

2210 M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

FAIRLAND REHABILITATION CTR

4b. City, Town, or Location of Death

SILVER SPRING

4c. County of Death

MONTGOMERY

5. Social Security Number

467-70-9491

6. Sex

 M F

7. Age (In yrs. last birthday)

68

Yrs.

If Under 1 Year

If Under 24 Hrs.

Months

Days

Hours

Min.

8. Date of Birth

Month

Day

Year

8/29/44

9. Birthplace (State or Foreign Country)

TEXAS

Usual Residence of Decedent

10a. State

MD

10b. County

PRINCE GEO

10c. City, Town or Location

LAUREL

10d. Inside City Limits

 Yes No

10e. Street and Number

37 ORCHARD TOWNE CT

10f. Zip Code

20707

10g. Citizen of What Country

USA

11. Marital Status

1 Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No)
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

SOFTWARE ENG

16b. Kind of Business/Industry

KEANE Falls Systems

17. Father's Name (First, Middle, Last)

HERBERT KARL BAIZE

18. Mother's Name (First, Middle, Maiden Surname)

LUCILLE DIPPOL

19a. Informant's Name/Relationship (Type, Print)

ALLISON M BAIZE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9516 MELLOW CT, LAUREL MD 20723

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ANYWHERE

Date

20c. Location - City or Town, State

HANOVER, MD

21. Signature of Funeral Service Licensee

CLIFFORD BURKE

22. Name and Address of Facility

HOUSER FUNERAL HOME
10220 BURLFORD RD., WESLEY, MD 20754

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. ACUTE CARDIOPULMONARY FAILURE

Due to (or as a consequence of):

b. METASTATIC RENAL CELL CARCINOMA

Due to (or as a consequence of):

c. CHRONIC HYPERTENSION

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No9 Unknown

23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify)9 Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

25. Was case referred to medical examiner?

1 Yes 2 No

26. Place of Death (Check only one)

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural2 Accident3 Suicide4 Homicide5 Pending investigation6 Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

M

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

► J. B. Gomez

29c. License number

DB3232

29d. Date signed (Month, Day, Year)

3/9/12

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Patricia Gomez 15245 Shady Grove Rd. Rockville, MD 20850

31. Date filed (Month, Day, Year)

MAR 13 2012

32. Registrar's Signature

Patricia Gomez

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

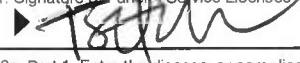
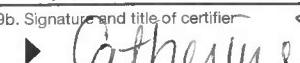
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07674

1- For
State
RegistrarPhysician/
Medical
Examiner

		1. Decedent's Name (First, Middle, Last) GEORGE BROWN						2. Date of Death Month 03 Day 11 Year 12 1234 AM		3. Time of Death											
		4a. Facility Name (if not institution, give street and number) UNIVERSITY OF MARYLAND						4b. City, Town, or Location of Death BALTIMORE		4c. County of Death											
Funeral Director		5. Social Security Number 202-09-8751		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 91 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.											
To Be Completed by Funeral Director		10a. State PA		10b. County Centre		10c. City, Town or Location Philipsburg						10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No									
		10e. Street and Number 416 S. Centre Street		10f. Zip Code 16866		10g. Citizen of What Country? U.S.A.															
		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates 42-45		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: White				14. Race - American Indian, Black, White, etc.											
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Clerk		16b. Kind of Business/Industry University															
		17. Father's Name (First, Middle, Last) George Brown						18. Mother's Name (First, Middle, Maiden Surname) Rachael Mayhew													
		19a. Informant's Name/Relationship (Type, Print) Dorothy Dixon Brown			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 416 S. Centre St., Philipsburg, PA 16866			19c. Date			20c. Location - City or Town, State Glen Burnie, MD										
		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) Atlantic Crem.			20b. Place of Disposition (Name of cemetery, crematory or other place) Atlantic Crem.			20c. Date 3/13/13													
		21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Harman Funeral Service 7221 Grayburn Dr., Glen Burnie, MD 21061																
Physician Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part II. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year									
		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown						23f. Did alcohol contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown													
		23g. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						23h. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No													
		25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		Hospital:		26. Place of Death (Check only one) 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) HOME		27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of injury (Month, Day, Year) 3/9/12		28b. Time of injury 1030 AM		28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred FALL	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) HOME						28f. Location (Street and Number or Rural Route Number, City or Town, State) 6410 HOME BUILDER DRIVE, MT AIRY, MD													
		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						29c. License number RES 001				29d. Date signed (Month, Day, Year) 3/11/12									
		29b. Signature and title of certifier 																			
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CATHERINE NELSON 22 S GREENST BALTIMORE MD 21201																			
		31. Date filed (Month, Day, Year) MAR 13 2012		32. Registrar's Signature 																	

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07675

1 - For State Registrar		1. Decedent's Name (First, Middle, Last) <i>Lorie Brand</i>				2. Date of Death Month Day Year <i>March 9, 2012</i>		3. Time of Death <i>0428 M</i>		
Physician/ Medical Examiner		4a. Facility Name (if not institution, give street and number) <i>BON SECOURS HOSP</i>				4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death <i>N/A</i>		
Funeral Director		5. Social Security Number <i>awc</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (in yrs. last birthday) <i>51</i> Yrs.	If Under 1 Year Months <input type="checkbox"/> Days Hours Min.	If Under 24 Hrs. <input type="checkbox"/> Hours <input type="checkbox"/> Min.	8. Date of Birth (Month, Day, Year) <i>Oct. 6, 1960</i>	9. Birthplace (State or Foreign Country) <i>MD</i>	
To Be Completed by Funeral Director		Usual Residence of Decedent 10a. State <i>Md.</i> 10b. County <i>N/A</i>				10c. City, Town or Location <i>Baltimore</i>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
To Be Completed by Physician/Medical Examiner		10e. Street and Number <i>938 Stoddard Ct.</i>				10f. Zip Code <i>21201</i>		10g. Citizen of What Country? <i>USA</i>		
Physician/ Medical Examiner		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <i>Cuban</i>		14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>		
Medical Certificate: To Be Completed by Physician/Medical Examiner		15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>2 yrs. private duty nurse</i>		16b. Kind of Business Industry <i>Nursing</i>				
To Be Completed by Physician/Medical Examiner		17. Father's Name (First, Middle, Last) <i>King Warren Brand</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>minnie Ruth Knight</i>				
Physician/ Medical Examiner		19a. Informant's Name/Relationship (Type, Print) <i>minnie R. Brand - mother</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1600 W. Mt. Royal #914 Balt., MD 21217</i>				
To Be Completed by Physician/Medical Examiner		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>mt. Zion Cem</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>mt. Zion Cem</i>		Date <i>3-16-2012</i>	20c. Location - City or Town, State <i>Lansdowne, Md.</i>			
To Be Completed by Physician/Medical Examiner		21. Signature of Funeral Service Licensee <i>Steven M. Wallace</i>				22. Name and Address of Facility <i>3405 W. Franklin St. 21229 Nancy M. Wallace F.S. Balt., MD</i>				
To Be Completed by Physician/Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>CANDIDEMIA</i>				Approximate Interval Between Onset and Death				
To Be Completed by Physician/Medical Examiner		a. Due to (or as a consequence of): <i>CANDIDEMIA</i>								
To Be Completed by Physician/Medical Examiner		b. Due to (or as a consequence of):								
To Be Completed by Physician/Medical Examiner		c. Due to (or as a consequence of):								
To Be Completed by Physician/Medical Examiner		d. Due to (or as a consequence of):								
To Be Completed by Physician/Medical Examiner		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year		
To Be Completed by Physician/Medical Examiner		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
To Be Completed by Physician/Medical Examiner						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
To Be Completed by Physician/Medical Examiner						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
To Be Completed by Physician/Medical Examiner		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
To Be Completed by Physician/Medical Examiner		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
To Be Completed by Physician/Medical Examiner				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
To Be Completed by Physician/Medical Examiner		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <i>00060225</i>				29d. Date signed (Month, Day, Year) <i>March 13, 2012</i>		
To Be Completed by Physician/Medical Examiner		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Steven HAMILLETT, MD</i>		31. Date filed (Month, Day, Year) <i>MAR 13 2012</i>				32. Registrar's Signature <i>Steven H. Hamill</i>		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07676

1 - For
State
Registrar

Physician/
Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

State
Registrar

1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
Clarence M. Blackburn		Month March 9, 2012 Day Year		12:55a M
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
Golden Living		Westminster		Carroll
5. Social Security Number 212-03-3461		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 94 Yrs.	If Under 1 Year Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 8/15/1917
Usual Residence of Decedent		9. Birthplace (State or Foreign Country) MD		
10a. State MD	10b. County Carroll	10c. City, Town or Location Westminster		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number 1330 Boerner Road		10f. Zip Code 21157		10g. Citizen of What Country? USA
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates. WWII	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) excavator		16b. Kind of Business Industry excavation
17. Father's Name (First, Middle, Last) Melvin P. Blackburn			18. Mother's Name (First, Middle, Maiden Surname) Margaret Baker	
19a. Informant's Name/Relationship (Type, Print) Rusling D. Blackburn, son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1330 Boerner Rd., Westminster, MD 21157		
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Carroll Cremation		Date 3/12/2012
21. Signature of Funeral Service Licensee ► Linda L Lemmer M00741		22. Name and Address of Facility Eline Funeral Home 934 S. Main Street. Hampstead, MD 21074		
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
<p>a. Due to (or as a consequence of): Cerebrovascular Disease</p> <p>b. Due to (or as a consequence of): Advanced age</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p> <p>Approximate Interval Between Onset and Death 15 yrs 94 yrs</p>				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Describe how injury occurred
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number D25443		
29b. Signature and title of certifier John W. Blackburn, MD		29d. Date signed (Month, Day, Year) 3/10/2012		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John W. Blackburn, MD, 688 Park Rd., Westminster, MD 21157				
31. Date filed (Month, Day, Year) MAR 13 2012		32. Registrar's Signature Anna J. Parker		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07677

1 - For
State
Registrar

Physician/
Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

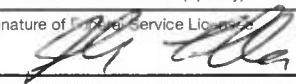
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Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Eva May Bywaters		2. Date of Death Month 3 Day 10 Year 2012		3. Time of Death M 2:15 A M
4a. Facility Name (if not institution, give street and number) Franklin Square Hospital		4b. City, Town, or Location of Death Rosedale		4c. County of Death Baltimore
5. Social Security Number 217-36-4077		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) 86 Yrs.	If Under 1 Year Months Days Hours Min.
8. Date of Birth (Month, Day, Year) July 19, 1925		9. Birthplace (State or Foreign Country) VA		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
10a. State MD		10b. County Baltimore		10c. City, Town or Location Essex
10e. Street and Number 422 Torner Road		10f. Zip Code 21221		10g. Citizen of What Country? USA
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry own home
17. Father's Name (First, Middle, Last) Fred Henry		18. Mother's Name (First, Middle, Maiden Surname) Betty Jewell		
19a. Informant's Name/Relationship (Type, Print) Jade Bywaters /daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 422 Torner Road Baltimore MD 21221		
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Bayview Crematory		Date 3/12/12
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility 300 Mace Ave. Balto. MD Connally Funeral Home of Essex 21221		20c. Location - City or Town, State Baltimore MD
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Coronary Artery Disease		Approximate Interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		<p>a. Due to (or as a consequence of): Coronary Artery Disease</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. _____</p>		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Urinary Tract Infection				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year) 	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number D0063327 29d. Date signed (Month, Day, Year) 03/10/2012		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Gizaw Woldehiwot 900 Franklin Square Dr, BaltO, MD, 21237		31. Date filed (Month, Day, Year) MAR 13 2012 32. Registrar's Signature 		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2012 07678

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1 - For
State
Registrar

**Physician/
Medical
Examiner**

**Funeral
Director**

To Be Completed by Funeral Director

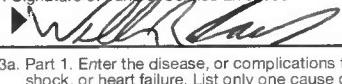
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death	
Elizabeth Ann Baumgardner		Month March		Day 10 Year 2012	
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death	
2001 Rudy Serra Drive Apt. 2-B		Eldersburg		Carroll	
5. Social Security Number 220-10-5570		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours
Usual Residence of Decedent Md Carroll		10c. City, Town or Location Eldersburg		8. Date of Birth (Month, Day, Year) 07/26/1921	
10a. State Md		10b. County Carroll		9. Birthplace (State or Foreign Country) Maryland	
10e. Street and Number 2001 Rudy Serra Dr. Apt. 2-B		10f. Zip Code 21784		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary		16b. Kind of Business/Industry Secretary Ft. Dietrick	
17. Father's Name (First, Middle, Last) George Montgomery		18. Mother's Name (First, Middle, Maiden Surname) Julia Blumenauer			
19a. Informant's Name/Relationship (Type, Print) Joanne E. Tart (Daughter)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6835 Littlewood Ct. Eldersburg, Md. 21784.			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Olivet		Date 03/13/2012	20c. Location - City or Town, State Frederick, Md.
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Haight Funeral Home & Chapel P.O. Box 195 Sykesville, Md. 21784.			
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. Due to (or as a consequence of): Pulmonary Edema		15mths	
		b. Due to (or as a consequence of): Congestive heart failure		20 yrs.	
		c. Due to (or as a consequence of): Coronary artery disease			
		d.			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number D16206		29d. Date signed (Month, Day, Year) 3/12/2012	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Elizabeth Pallan M.D. 1380 Progress Way Eldersburg, Md. 21784.					
31. Date filed (Month, Day, Year) MAR 13 2012		32. Registrar's Signature 			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2012 07679

Reg. No.

1 - For
State
RegistrarPhysician/
Medical
Examiner

		1. Decedent's Name (First, Middle, Last) VIRGILIO BEINONES			2. Date of Death Month 3 Day 8 Year 2012		3. Time of Death 7:30 A M		
		4a. Facility Name (if not institution, give street and number) Crawford Retreat			4b. City, Town, or Location of Death Baltimore		4c. County of Death		
Funeral Director		5. Social Security Number 430-45-5991	6. Sex 1 X M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 80 Yrs.	If Under 1 Year Months 0 Days 0	If Under 24 Hrs. Hours 0 Min. 0	8. Date of Birth (Month, Day, Year) April 4 1931	9. Birthplace (State or Foreign Country) Cuba	
To Be Completed by Funeral Director		10a. State MD	10b. County	10c. City, Town or Location Baltimore City				10d. Inside City Limits 1 X Yes 2 <input type="checkbox"/> No	
		10e. Street and Number 2117 Denison Street			10f. Zip Code 21216		10g. Citizen of What Country? USA		
		11. Marital Status 1 <input type="checkbox"/> Never Married 2 X Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 X No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Yes 2 <input type="checkbox"/> No Specify: Cuban		14. Race - American Indian, Black, White, etc. white		
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unknown			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) farmer		16b. Kind of Business/Industry agriculture		
		17. Father's Name (First, Middle, Last) unknown			18. Mother's Name (First, Middle, Maiden Surname) unknown				
		19a. Informant's Name/Relationship (Type, Print) Sharon Corwell (caregiver)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2117 Denison St., Baltimore, MD 21216				
		20a. Method of Disposition 1 X Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Springfield Cem.		Date 3-12-12	20c. Location - City or Town, State Sykesville, MD		
		21. Signature of Funeral Service Licensee Dawn Haight Hersent			22. Name and Address of Facility Haight Funeral Home & Chapel P.O. Box 195 Sykesville, MD 21784				
Physician/ Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)			<i>A acute Myocardial Infarction</i>			Approximate Interval Between Onset and Death	
		a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
Medical Certificate: To Be Completed by Physician/Medical Examiner		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia			23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				
		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			23f. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
		27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year) 1 <input type="checkbox"/> At home, farm, street, factory, office building, etc. (Specify)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
		29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number D26748				29d. Date signed (Month, Day, Year) 3/8/2012	
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANIL UBEROI 4419 FALLS RD BALTIMORE MD 21211							
State Registrar		31. Date filed (Month, Day, Year) MAR 13 2012		32. Registrar's Signature Anil J. Uberoi					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

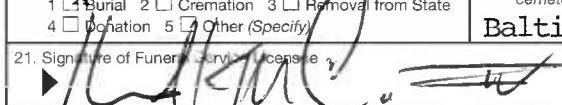
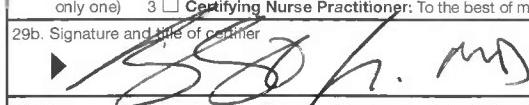
Certificate of Death

Reg. No.

2012 07680

1 - For
State
Registrar

Physician/
Medical
Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death					
Doris Rose Bryant		Month March 11, Day 2012 Year		3:00 P M					
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death					
Upper Chesapeake Medical Center		Forest Hill		Harford					
5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	8. Date of Birth		9. Birthplace (State or Foreign Country)			
219-10-1825		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	86 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	Hours	Min.	Dec. 2, 1925	Maryland
Usual Residence of Decedent		10a. State Maryland		10b. County Harford		10c. City, Town or Location Forest Hill		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 1713 Landmark Dr.		10f. Zip Code 21050		10g. Citizen of What Country? USA					
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Homemaker		16b. Kind of Business/Industry Own Home					
17. Father's Name (First, Middle, Last) Joseph Albert Hoffman		18. Mother's Name (First, Middle, Maiden Surname) Anna Elizabeth Sparr							
19a. Informant's Name/Relationship (Type, Print) Cheryl Gallion / Friend		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2228 Warfield Dr., Forest Hill, Maryland 21050							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore Cemetery		Date 3-14-2012		20c. Location - City or Town, State Baltimore, Maryland			
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		a. probable myocardial infarction		Approximate Interval Between Onset and Death					
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. Due to (or as a consequence of):							
c. Due to (or as a consequence of):		d. Due to (or as a consequence of):							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> D.O.A. Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		23f. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number 00057223		29d. Date signed (Month, Day, Year) 3/12/12					
29b. Signature and title of certifier 									
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jermie Barron Jr. MD, 300 Upper Chesapeake Dr., Bel Air MD 21004									
31. Date filed (Month, Day, Year) MAR 13 2012		32. Registrar's Signature Laura J. Park							

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

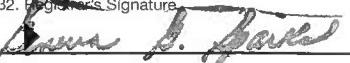
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07681

1- For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Julia Lochary Boggs							2. Date of Death Month March Day 9 , Year 2012	3. Time of Death 8:26 A M
	4a. Facility Name (if not institution, give street and number) Brightview Assisted Living			4b. City, Town, or Location of Death Bel Air			4c. County of Death Harford		
Funeral Director	5. Social Security Number 214-22-6658	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months <input type="checkbox"/> Days <input type="checkbox"/>	If Under 24 Hrs. Hours <input type="checkbox"/> Min. <input type="checkbox"/>	8. Date of Birth (Month, Day, Year) Aug. 10, 1926	9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent 10a. State Maryland 10b. County Harford			10c. City, Town or Location Bel Air			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number 207 A Crocker Drive			10f. Zip Code 21014			10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Book Processor			16b. Kind of Business Industry County Government		
	17. Father's Name (First, Middle, Last) Frederick S. Lochary				18. Mother's Name (First, Middle, Maiden Surname) Clara (unk) Poole				
	19a. Informant's Name/Relationship (Type, Print) Faith Barr / Foster Child			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1749 Perryville Road, Perryville, Maryland 21903					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Rose Hill Svcs. LLC			Date 3/12/2012	20c. Location - City or Town, State Bel Air, Maryland	
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility McComas Funeral Home, P.A.			1317 Cokesbury Road, Abingdon, Maryland 21009		
Physician/ Medical Examiner	<p>23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line.</p> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of):</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> <p>b. ATRIAL FIBRILLATION Due to (or as a consequence of):</p> <p>c. TEMPORAL ARTERITIS Due to (or as a consequence of):</p> <p>d.</p> <p>IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____</p> <p>23d. Date of delivery Month Day Year</p>								
Medical Certificate: To Be Completed by Physician/Medical Examiner	<p>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</p> <p>ATRIAL FIBRILLATION</p> <p>TEMPORAL ARTERITIS</p> <p>23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown</p> <p>23f. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>								
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA			Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Assisted Living		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29c. License number D25027			29d. Date signed (Month, Day, Year) MARCH 9 2012		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VIJAY M. ASHYAKAR & NORTH AVE BEL AIR MD 21014			31. Date filed (Month, Day, Year) MAR 13 2012			32. Registrar's Signature 		

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07682

1 - For
State
Registrar

Physician/
Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

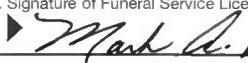
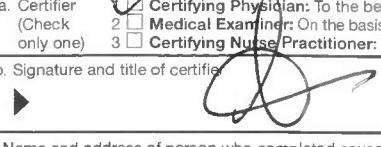
Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trust.

1. Decedent's Name (First, Middle, Last) Elizabeth Joyce Barranger			2. Date of Death Month 03 Day 07 Year 2012		3. Time of Death 9:50 PM						
4a. Facility Name (if not institution, give street and number) Heritage Harbour Health Center			4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arundel						
5. Social Security Number 219-03-2527		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 92 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.						
Usual Residence of Decedent MD Anne Arundel		8. Date of Birth (Month, Day, Year) 10/06/1919				9. Birthplace (State or Foreign Country) MD					
10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Glen Burnie			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
10e. Street and Number 201 Somerset Bay Drive Apt. 103			10f. Zip Code 21061			10g. Citizen of What Country? U.S.A.					
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Administrative Assistant			16b. Kind of Business/Industry Howard County Government					
17. Father's Name (First, Middle, Last) William B. Welden				18. Mother's Name (First, Middle, Maiden Surname) Bertha Elizabeth Joyce							
19a. Informant's Name/Relationship (Type, Print) Mrs. Patricia J. Bredon / daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7912 Oak Road, Pasadena, Maryland 21122								
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Atlantic Crematory			Date 3/09/2012	20c. Location - City or Town, State Glen Burnie, Maryland				
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility 1 2nd Ave, SW Glen Burnie, MD M01357 Singleton Funeral & Cremation Services, P.A.								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death			
<p>a. Due to (or as a consequence of): Cardiac Amyotonia</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>											
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown						23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Failure to thrive								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						23d. Date of delivery Month Day Year			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred					
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								29b. Signature and title of certifier 		29c. License number D57028	29d. Date signed (Month, Day, Year) march 8, 2012
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Aditya Chopra MD 660 Ridgely Ave Ste 231 Annapolis MD 21401											
31. Date filed (Month, Day, Year) MAR 13 2012		32. Registrar's Signature 									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend Items 23aPtI, 11, 27, 28a-f, pe me, 8926, 04/19/2012dmb Certificate of Death

Reg. No. 2012 07683

1 - For State Registrar

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death			
Shirley M. Baker	March 6 2012	12:27 PM			
4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death			
Baltimore Washington Medical Center	Glen Burnie	Anne Arundel			
5. Social Security Number	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 08/11/1930	9. Birthplace (State or Foreign Country) NY
Usual Residence of Decedent			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10a. State MD	10b. County Anne Arundel	10c. City, Town or Location Glen Burnie			
10e. Street and Number 14 Cromwell Avenue			10f. Zip Code 21061		10g. Citizen of What Country? U.S.A.
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary			16b. Kind of Business/Industry City of Baltimore
17. Father's Name (First, Middle, Last) Harry Stock			18. Mother's Name (First, Middle, Maiden Surname) Jennie Bergen		
19a. Informant's Name/Relationship (Type, Print) Mr. Robert E. Baker, Jr. / son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 105 Crestview Drive, Brandon, Florida 33511			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Atlantic Crematory		20b. Place of Disposition (Name of cemetery, crematory or other place) Atlantic Crematory		Date 3/9/2012	20c. Location - City or Town, State Glen Burnie, Maryland
21. Signature of Funeral Service Licensee Mark A. Van		22. Name and Address of Facility 1 2nd Ave, SW Glen Burnie, MD M01357 Singleton Funeral & Cremation Services, P.A.			

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) _____		23d. Date of delivery Month Day Year
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown						
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____		27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) 02/28/2012 28b. Time of Injury Unknown 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
28d. Describe how injury occurred Subject tripped and fell.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Home		28f. Location (Street and Number or Rural Route Number, City or Town, State) 14 Cromwell Avenue, Glen Burnie, MD		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
29b. Signature and title of certifier R Mukherjee MD		29c. License number D65911		29d. Date signed (Month, Day, Year) March 6th 2012		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7845 Oakwood Road Suite 106 Glen Burnie 21061		31. Date filed (Month, Day, Year) MAR 13 2012 32. Registrar's Signature Anna S. Park				

OK per me
Division of Vital Records, P.O. Box 68760, RS
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

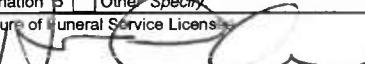
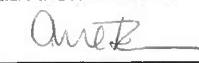
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07684

1- For State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Joshua R. Burgess				2. Date of Death Month <input type="text"/> March Day <input type="text"/> 7 Year <input type="text"/> 2012	3. Time of Death 1249 hrs	
	4a. Facility Name (if not institution, give street and number) St. Agnes Hospital		4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A		
Funeral Director	5. Social Security Number 217-29-7737	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 21 Yrs.	If Under 1 Year Months <input type="text"/> Days <input type="text"/> Hours <input type="text"/> Min. <input type="text"/>	8. Date of Birth (MM/DD/YYYY) 8/12/90	9. Birthplace (State or Foreign Country) MD	
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State MD 10b. County Baltimore 10c. City, Town or Location Randlestow n						10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number 9017 Hamor Road			10f. Zip Code 21133	10g. Citizen of What Country? USA		
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No specify:		14. Race - American Indian, Black, White, etc. African American Specify:	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Customer Service		16b. Kind of Business/Industry Home Depot		
	17. Father's Name (First, Middle, Last) Randel Burgess			18. Mother's Name (First, Middle, Maiden Surname) Pamela Garrett			
	19a. Informant's Name/Relationship (Type, Print) Randel Burgess		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9017 Hamor Road, Randlestow, MD 21133				
Physician Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other Specify		20b. Place of Disposition (Name of cemetery, crematory or other place) King Memorial Pk		Date 3/16/12	20c. Location - City or Town, State Balt. Cty, MD	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Hari P. Close F. Sys PA 5126 Belair Rd, Balt., MD 21206-5105				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.						
	Approximate Interval Between Onset and Death						
	Immediate Cause (Final disease or condition resulting in death)						
	a. Myocarditis Due to (or as a consequence of):						
	b. _____ Due to (or as a consequence of):						
	c. _____ Due to (or as a consequence of):						
	d. _____						
	<input checked="" type="checkbox"/> UNPENDED		<input type="checkbox"/> AMENDED 23a, 27, per me, g926 4-24-12 sm				
	IF FEMALE:		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month <input type="text"/> Day <input type="text"/> Year <input type="text"/>	
	23b. Was decedent pregnant in the past 12 months?						
	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown						
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown						
	24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						
	Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other:						
	26. Place of Death (Check only one)						
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide						
	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 <input type="checkbox"/> Yes <input type="checkbox"/> No						
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						
	28d. Describe how injury occurred						
	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
	29b. Signature and title of certifier 						
	29c. License number O.C.M.E.						
	29d. Date signed (Month, Day, Year) March 8, 2012						
	30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223						
	31. Date filed (Month, Day, Year) MAR 13 2012		32. Registrar's Signature 				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07685

1 - For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Robert E. Callahan</i>						2. Date of Death Month 03 Day 10 Year 2012	3. Time of Death 5:44 PM								
	4a. Facility Name (If not institution, give street and number) <i>University of Maryland Medical Center</i>			4b. City, Town, or Location of Death <i>Baltimore</i>			4c. County of Death N/A									
Funeral Director	5. Social Security Number 218-18-7018	6. Sex 1 X M 2 □ F	7. Age (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) May 3, 1923	9. Birthplace (State or Foreign Country) Maryland									
To Be Completed by Funeral Director	10a. State MD	10b. County Howard	10c. City, Town or Location Ellicott City				10d. Inside City Limits 1 □ Yes 2 X No									
	10e. Street and Number 8530 Marybeth Way			10f. Zip Code 21043		10g. Citizen of What Country? USA										
	11. Marital Status 1 X Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 X No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 X No Specify:			14. Race - American Indian, Black, White, etc. White									
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Salesman		16b. Kind of Business/Industry Domino Sugar												
	17. Father's Name (First, Middle, Last) George W. Callahan			18. Mother's Name (First, Middle, Maiden Surname) May H. Michael												
	19a. Informant's Name/Relationship (Type, Print) Cheryl C. Post, niece		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5022 Alice Avenue Ellicott City, MD 21043													
	20a. Method of Disposition 1 □ Burial 2 X Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc.		Date 03/12/12	20c. Location - City or Town, State Baltimore, MD										
Physician/ Medical Examiner	21. Signature of Funeral Service Licensee <i>George MacNabb</i>		22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228													
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last															
	<table border="0"> <tr> <td>a. <i>Ischemic Cardiomyopathy</i></td> <td>Approximate Interval Between Onset and Death 3 days</td> </tr> <tr> <td>b. <i>Hypoxic respiratory failure</i></td> <td></td> </tr> <tr> <td>c. _____</td> <td></td> </tr> <tr> <td>d. _____</td> <td></td> </tr> </table>								a. <i>Ischemic Cardiomyopathy</i>	Approximate Interval Between Onset and Death 3 days	b. <i>Hypoxic respiratory failure</i>		c. _____		d. _____	
a. <i>Ischemic Cardiomyopathy</i>	Approximate Interval Between Onset and Death 3 days															
b. <i>Hypoxic respiratory failure</i>																
c. _____																
d. _____																
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 X No 9 □ Unknown		23c. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown				23d. Date of delivery Month Day Year									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Coronary artery disease</i>															
	23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 □ Probably 4 X Unknown															
	<table border="0"> <tr> <td>24a. Was an autopsy performed? 1 □ Yes 2 X No</td> <td>24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No</td> </tr> </table>								24a. Was an autopsy performed? 1 □ Yes 2 X No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No						
24a. Was an autopsy performed? 1 □ Yes 2 X No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No															
Medical Certificate: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 □ Yes 2 X No	26. Place of Death (Check only one) 1 X Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)														
	27. Manner of Death 1 X Natural 5 □ Pending Investigation 2 □ Accident 6 □ Could not be determined 3 □ Suicide 4 □ Homicide	28a. Date of injury (Month, Day, Year) M		28b. Time of injury M	28c. Injury at work? 1 □ Yes 2 □ No	28d. Describe how injury occurred										
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State) City or Town, State													
	29a. Certifier (Check only one) 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 □ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	29c. License number NPI 1093030553		29d. Date signed (Month, Day, Year) 3/10/12												
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael Quartuccio 22 South Green St. Baltimore, MD 21201															
State Registrar	31. Date filed (Month, Day, Year) MAR 13 2012		32. Registrar's Signature <i>[Signature]</i>													

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Robert E. Callahan</i>		2. Date of Death Month 03 Day 10 Year 2012	3. Time of Death 5:44 PM												
	4a. Facility Name (If not institution, give street and number) <i>University of Maryland Medical Center</i>		4b. City, Town, or Location of Death <i>Baltimore</i>													
Funeral Director	5. Social Security Number 218-18-7018	6. Sex 1 X M 2 □ F	7. Age (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months Days												
	8. Date of Birth (Month, Day, Year) May 3, 1923		9. Birthplace (State or Foreign Country) Maryland													
To Be Completed by Funeral Director	10a. State MD	10b. County Howard	10c. City, Town or Location Ellicott City													
	10e. Street and Number 8530 Marybeth Way			10f. Zip Code 21043												
	11. Marital Status 1 X Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 X No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 X No Specify:												
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Salesman		16b. Kind of Business/Industry Domino Sugar												
	17. Father's Name (First, Middle, Last) George W. Callahan			18. Mother's Name (First, Middle, Maiden Surname) May H. Michael												
	19a. Informant's Name/Relationship (Type, Print) Cheryl C. Post, niece		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5022 Alice Avenue Ellicott City, MD 21043													
	20a. Method of Disposition 1 □ Burial 2 X Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc.		Date 03/12/12	20c. Location - City or Town, State Baltimore, MD										
Physician/ Medical Examiner	21. Signature of Funeral Service Licensee <i>George MacNabb</i>		22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228													
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last															
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a. <i>Ischemic Cardiomyopathy</i>	Approximate Interval Between Onset and Death 3 days															
b. <i>Hypoxic respiratory failure</i>																
c. _____																
d. _____																
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 X No 9 □ Unknown		23c. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown				23d. Date of delivery Month Day Year									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Coronary artery disease</i>															
	23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 □ Probably 4 X Unknown															
	<table border="0"> <tr> <td>24a. Was an autopsy performed? 1 □ Yes 2 X No</td> <td>24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No</td> </tr> </table>								24a. Was an autopsy performed? 1 □ Yes 2 X No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No						
24a. Was an autopsy performed? 1 □ Yes 2 X No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No															
Medical Certificate: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 □ Yes 2 X No	26. Place of Death (Check only one) 1 X Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)														
	27. Manner of Death 1 X Natural 5 □ Pending Investigation 2 □ Accident 6 □ Could not be determined 3 □ Suicide 4 □ Homicide	28a. Date of injury (Month, Day, Year) M		28b. Time of injury M	28c. Injury at work? 1 □ Yes 2 □ No	28d. Describe how injury occurred										
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State) City or Town, State													
	29a. Certifier (Check only one) 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 □ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	29c. License number NPI 1093030553		29d. Date signed (Month, Day, Year) 3/10/12												
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael Quartuccio 22 South Green St. Baltimore, MD 21201															
State Registrar	31. Date filed (Month, Day, Year) MAR 13 2012		32. Registrar's Signature <i>[Signature]</i>													

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07686

1 - For
State
Registrar

Physician/
Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death			3. Time of Death			
Charles Curtis			Month March Day 7th Year 2012			N/A			
4a. Facility Name (if not institution, give street and number)			4b. City, Town, or Location of Death			4c. County of Death			
Union Memorial Hospital			Baltimore			N/A			
5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)		If Under 1 Year		If Under 24 Hrs.		
214-54-3341		1 M	62 Yrs.		Months	Days	Hours	Min.	
8. Date of Birth (Month, Day, Year)		9. Birthplace (State or Foreign Country)							
12-25-1949		MD							
10a. State			10b. County		10c. City, Town or Location				
MD			N/A		Baltimore				
10e. Street and Number			10f. Zip Code			10g. Citizen of What Country?			
2423 Barclay St.			21218			USA			
11. Marital Status			12. Was Decedent Ever in U.S. Armed Forces?			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			14. Race - American Indian, Black, White, etc.
1 Never Married			1 Yes			1 Yes			Specify: Black
3 Widowed			2 No			If Yes, Give Year or Dates.			
4 Divorced									
15. Decedent's Education (Specify only highest grade completed)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired)			16b. Kind of Business/Industry			
Elementary/Secondary (0-12) 2nd			Disabled						N/A
College (1-4 or 5+) N/A									
17. Father's Name (First, Middle, Last)			18. Mother's Name (First, Middle, Maiden Surname)						
George Handy			Julia Queen						
19a. Informant's Name/Relationship (Type, Print)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)			20c. Location - City or Town, State			
Regina Curtis - Sister			2423 Barclay St. Baltimore, MD 21218			3/15/2012			Randallsown, MD
20a. Method of Disposition			20b. Place of Disposition (Name of cemetery, crematory or other place)			Date			
1 Burial			King Memorial Park			3/15/2012			
2 Cremation									
3 Removal from State									
4 Donation									
5 Other (Specify)									
21. Signature of Funeral Service Licensee			22. Name and Address of Facility			23d. Date of delivery			
Brandi Martin			March 8th - East 1101 E. North Ave.			Month Day Year			
Baltimore, MD 21202									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)									
a. Mycocardial Infarction Due to (or as a consequence of):									
b. Massive GI Bleeding Due to (or as a consequence of):									
c. _____ Due to (or as a consequence of):									
d. _____									
IF FEMALE:			23c. If yes, outcome of pregnancy			23d. Date of delivery			
23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown			1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown			Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									23e. Did tobacco use contribute to the cause of death?
									1 Yes 2 No 3 Probably 4 Unknown
25. Was case referred to medical examiner? 1 Yes 2 No			26. Place of Death (Check only one)			23f. Was an autopsy performed? 1 Yes 2 No			24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)									
27. Manner of Death			28a. Date of injury (Month, Day, Year)			28b. Time of injury			28c. Injury at work? 1 Yes 2 No
1 Natural 5 Pending Investigation 2 Accident 6 Could not be determined			M						28d. Describe how injury occurred
3 Suicide 4 Homicide			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier			29c. License number			29d. Date signed (Month, Day, Year)			
DANIEL TEKAY			D 57447			March 7th, 2012			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)									
DANIEL TEKAY 201 E. University Parkway, Baltimore, MD 21228									
31. Date filed (Month, Day, Year)			32. Registrar's Signature						
MAR 13 2012			J. Spada						

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#8perFH/30perDVR,G925,3/13/2012,WS
State of Maryland / Department of Health and Mental Hygiene

1 - For
State
Registrar

Certificate of Death

Reg. No. 2012 07587

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) Eun Shik Chang						2. Date of Death Month Month Day Year March 6 2012		3. Time of Death M M H H M 1840 M	
Funeral Director		4a. Facility Name (if not institution, give street and number) Holy Cross Hospital			4b. City, Town, or Location of Death Silver Spring			4c. County of Death Montgomery			
To Be Completed by Funeral Director		5. Social Security Number 173-76-7247	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (in yrs. last birthday) 65 Yrs.	If Under 1 Year Months 4	If Under 24 Hrs. Days 5	8. Date of Birth (Month, Day, Year) 5/26/1946	9. Birthplace (State or Foreign Country) Korea			
		10a. State MD	10b. County Montgomery	10c. City, Town or Location Burtonsville						10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
		10e. Street and Number 14301 Vivaldi Ct			10f. Zip Code 20864			10g. Citizen of What Country? USA			
		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Asian		
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Pastor			16b. Kind of Business/Industry Religion			
		17. Father's Name (First, Middle, Last) Nam Soo Chang			18. Mother's Name (First, Middle, Maiden Surname) Mak R Hong						
		19a. Informant's Name/Relationship (Type, Print) Jung Hee Chang			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14301 Vivaldi Ct, Burtonsville, MD 20864						
		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Ardent			Date 3/12/2012	20c. Location - City or Town, State Hanover, MD		
		21. Signature of Funeral Service Licensee Mia Deach			22. Name and Address of Facility Howell Funeral Home 10220 Guilford Rd, Jessup, MD						
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
		<p>a. <u>Advanced CLL</u> Due to (or as a consequence of):</p> <p>b. <u>Resp Failure with Pneumonia</u> Due to (or as a consequence of):</p> <p>c. <u>Anemia</u> Due to (or as a consequence of):</p> <p>d. <u>Thrombocytopenia</u></p>									
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Acute Renal Failure									
		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown									
		<p>24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</p> <p>24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>									
		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA			26. Place of Death (Check only one) Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred			
					28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
		29a. Certifier 1 <input type="checkbox"/> Certifying Physician 2 <input type="checkbox"/> Medical Examiner 3 <input type="checkbox"/> Certifying Nurse Practitioner			To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29d. Date signed (Month, Day, Year)			
		29b. Signature and title of certifier ► or Rahmanian			29c. License number D66372			29d. Date signed (Month, Day, Year) 3-6-12			
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Majid Rahamanian Holy Cross Hospital Silver Spring, MD									
State Registrar		31. Date filed (Month, Day, Year) MAR 13 2012			32. Registrar's Signature Janice S. Jones						

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-7 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07688

1 - For State Registrar

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) <i>Timothy W. Carr</i>			2. Date of Death Month <input checked="" type="checkbox"/> March Day <input checked="" type="checkbox"/> 10 Year <input checked="" type="checkbox"/> 2012	3. Time of Death <input checked="" type="checkbox"/> 2:55 AM
4a. Facility Name (If not institution, give street and number) <i>Johns Hopkins Bayview Medical</i>			4b. City, Town, or Location of Death <i>Baltimore</i>	
4c. County of Death				
5. Social Security Number <input checked="" type="checkbox"/> 234-88-3282	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 58 Yrs.	If Under 1 Year Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	8. Date of Birth (Month, Day, Year) <input checked="" type="checkbox"/> 10/13/1953
9. Birthplace (State or Foreign Country) <input checked="" type="checkbox"/> WV			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Usual Residence of Decedent 10a. State <input checked="" type="checkbox"/> MD		10b. County <input checked="" type="checkbox"/> Anne Arundel	10c. City, Town or Location <i>Glen Burnie</i>	
10e. Street and Number <i>6012 Helmsman Way</i>			10f. Zip Code <input checked="" type="checkbox"/> 21029	10g. Citizen of What Country? <input checked="" type="checkbox"/> U.S.A.
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: <input checked="" type="checkbox"/> White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input checked="" type="checkbox"/> 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Software Engineer</i>	16b. Kind of Business/Industry <input checked="" type="checkbox"/> Telecommunications	
17. Father's Name (First, Middle, Last) <i>Orville Ray Carr</i>			18. Mother's Name (First, Middle, Maiden Surname) <i>Phyllis Jean Nelson</i>	
19a. Informant's Name/Relationship (Type, Print) <input checked="" type="checkbox"/> Sue Hardesty		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>920 Judge Court, E. West River, MD 20778</i>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Sunset Mem. Park</i>	Date <input checked="" type="checkbox"/> 3-15-12	20c. Location - City or Town, State <input checked="" type="checkbox"/> South Charleston, WV
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <i>Harman Funeral Service 7221 Grayburn Drive, Glen Burnie, MD 21061</i>		

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

- a. *Pneumonia*
Due to (or as a consequence of):
- b. *Respiratory arrest*
Due to (or as a consequence of):
- c. Due to (or as a consequence of):
- d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
 Yes No
 Unknown23c. If yes, outcome of pregnancy
 Live birth Fetal death
 Pregnant at time of death
 Unknown3 Ectopic pregnancy
5 Other (specify) _____23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Interstitial lung disease

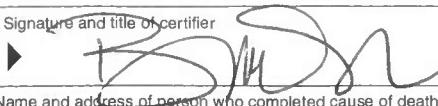
23e. Did tobacco use contribute to the cause of death?

 Yes No Probably Unknown25. Was case referred to medical examiner?
 Yes No27. Manner of Death
 Natural
 Accident
 Suicide
 Homicide26. Place of Death (Check only one)
Hospital: Inpatient ER/Outpatient DDA Other: Nursing Home Residence Other (Specify)28a. Date of Injury
(Month, Day, Year)28b. Time of Injury
M28c. Injury at Work?
 Yes No

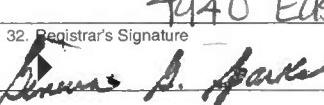
28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)
 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.29b. Signature and title of certifier
29c. License number
 DD 00029d. Date signed (Month, Day, Year)
 March 10 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

*Berenice Nava**1940 Eastern Avenue, Baltimore, MD 21224*31. Date filed (Month, Day, Year)
 MAR 13 201232. Registrar's Signature


ORIGINAL

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07689

1 - For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) HELEN L. CHART							2. Date of Death MARCH 9, 2012	3. Time of Death 5:45P M	
	4a. Facility Name (if not institution, give street and number) OAKCREST CARE CENTER				4b. City, Town, or Location of Death PARKVILLE			4c. County of Death BALTIMORE		
Funeral Director	5. Social Security Number 235-36-9860		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) 87	If Under 1 Year Months Yrs.	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) 12/9/1924	9. Birthplace (State or Foreign Country) WEST VIRGINIA		
To Be Completed by Funeral Director	10a. State MD		10b. County BALTIMORE		10c. City, Town or Location PARKVILLE			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 8832 WALTHER BLVD				10f. Zip Code 21234			10g. Citizen of What Country? USA		
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates 1952-1973		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. WHITE		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) NURSE		16b. Kind of Business/Industry US GOVERNMENT					
	17. Father's Name (First, Middle, Last) JOE CHART				18. Mother's Name (First, Middle, Maiden Surname) SOPHIE CHERRY					
	19a. Informant's Name/Relationship (Type, Print) NANCY CIOFFI - NIECE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16 FARNHAM WAY LUTHERVILLE, MD 21093					
Physician/ Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) GARDENS OF FAITH		Date 3/13/12	20c. Location - City or Town, State BALTIMORE, MD			
	21. Signature of Funeral Service Licensee Jubanick			22. Name and Address of Facility SCHIMUNEK FUNERAL HOME, INC 9705 BELAIR RD NOTTINGHAM, MD 21236						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Multi-infarct Dementia								Approximate Interval Between Onset and Death	
	<p>a. Due to (or as a consequence of): Multi-infarct Dementia</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Atrial fibrillation, MVP, cerebrovascular disease								23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		23f. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year) 28b. Time of injury M		28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) At home				28f. Location (Street and Number or Rural Route Number, City or Town, State) Parkville, MD 21234			
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input checked="" type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number R171944					29d. Date signed (Month, Day, Year) 3/9/12		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michelle G. Harrison NP 8800 Walther Blvd, Parkville MD 21234									
	31. Date filed (Month, Day, Year) MAR 13 2012		32. Registrar's Signature J. Parker							

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
 amend Item 20a-c per fh g925 3-14-12 vt
 State of Maryland / Department of Health and Mental Hygiene

1 - For
State
Registrar

Certificate of Death

Reg. No.

2012 07690

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

CIANFERANO, ALFREO WILLIAM

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death
Alfred William Cianferano , Jr.		March 8 2012		9:35AM
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
LOCH RAVEN VA CLRC		Baltimore		N/A
5. Social Security Number	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 10/24/1929
220-202002				9. Birthplace (State or Foreign Country) Baltimore, Maryland
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10a. State Maryland	10b. County N/A	10c. City, Town or Location Baltimore		
10e. Street and Number 4127 Falls Road		10f. Zip Code 21211		10g. Citizen of What Country? United States
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White	14. Race - American Indian, Black, White, etc. Specify: White	
Elementary/Secondary (0-12) 10	College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Printer	16b. Kind of Business/Industry Hecht Company	
17. Father's Name (First, Middle, Last) Alfred William Cianferano , Sr.		18. Mother's Name (First, Middle, Maiden Surname) Mildred (Unknown)		
19a. Informant's Name/Relationship (Type, Print) Jim Scallion / Nephew		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2041 Royal Pines Drive..New Benn, North Carolina, 28560		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of Facility) Atlantic Crematory Garrison Forest Vet. Cem	Date 11 3/15/2012	20c. Location - City or Town, State Glen Burnie Owings Mills, Maryland
21. Signature of Funeral Service Licensee Carol Myers		22. Name and Address of Facility Burgee Henss Seitz Funeral Home, Inc. 3631 Falls Road, Baltimore, Maryland 21211		
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
a. Due to (or as a consequence of): <i>multiple myeloma</i> b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Chronic Obstructive Pulmonary Disease</i> <i>Prolong Posttraumatic Stress</i>				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
29b. Signature and title of certifier M.D.		29c. License number 056508		29d. Date signed (Month, Day, Year) March 8, 2012
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3900 LOCH RAVEN BLVD.		31. Date filed (Month, Day, Year) MAR 13 2012		
		32. Registrar's Signature Lorraine J. Parker		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07591

1 - For
State
Registrar

**Physician/
Medical
Examiner**

Baltimore, Maryland 21215-0036
permit Page 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

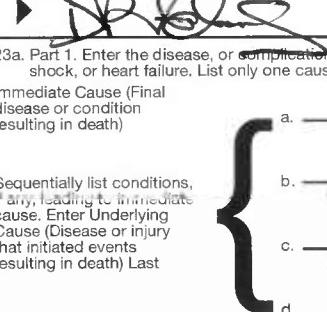
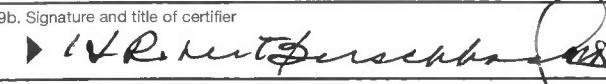
To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

State
Registrar

Division of Vital Records, P.O. Box 68760
To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
envelope.

1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
Pien Tseng Chang		Month March Day 11 Year 2012		4:50 P M
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
407 Russell Ave. #304		Gaithersburg		Montgomery
5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year
110-24-4083		1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	94 Yrs.	Months Days Hours Min.
Usual Residence of Decedent:				
10a. State	10b. County	10c. City, Town or Location		
MD	Montgomery	Gaithersburg		
10e. Street and Number		10f. Zip Code		10g. Citizen of What Country?
407 Russell Ave. #304		20877		United States
11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.			1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		
Elementary/Secondary (0-12)	College (1-4 or 5+)			16b. Kind of Business/Industry
5+		Engineer Shipping		
17. Father's Name (First, Middle, Last)			18. Mother's Name (First, Middle, Maiden Surname)	
Bow Shee Chang			Zi Yang Shan	
19a. Informant's Name/Relationship (Type, Print)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
Henry Chang / Son			6209 Plainview Rd., Bethesda, MD 20817	
20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City or Town, State
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		Chesapeake Crematory		Date 03/13/2012
21. Signature of Funeral Service Licensee		22. Name and Address of Facility		
		Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD 20910		
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				
Immediate Cause (Final disease or condition resulting in death)				
23b. Part 2. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				
Approximate Interval Between Onset and Death 1 MONTH				
23c. If female: Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown				
23d. Date of delivery Month Day Year				
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
23f. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
23g. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
24. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
26. Manner of Death Natural 5 <input type="checkbox"/> Pending Investigation Accident 6 <input type="checkbox"/> Could not be determined Suicide Homicide				
27. Date of injury (Month, Day, Year) 28. Time of injury M 29. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Describe how injury occurred				
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. Signature and title of certifier  29c. License number D04115 29d. Date signed (Month, Day, Year) March 12, 2012				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) H. ROBERT BIRSCHBACH M.D., 201 RUSSELL AVE., GAITHERSBURG, MD 20877				
31. Date filed (Month, Day, Year)		32. Registrar's Signature 		
MAR 13 2012				

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07692

1 - For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Arlene Becker Claxton					2. Date of Death Month 02 Year 2012	3. Time of Death 10:55 AM			
	4a. Facility Name (if not institution, give street and number) Emeritus of Towson			4b. City, Town, or Location of Death Baltimore		4c. County of Death				
Funeral Director	5. Social Security Number 578-24-4783	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 89 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 11-27-1922	9. Birthplace (State or Foreign Country) DC			
	Usual Residence of Decedent MD			10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
To Be Completed by Funeral Director	10e. Street and Number 6451 N. Charles Street, #350			10f. Zip Code 21212		10g. Citizen of What Country? USA				
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Realtor		16b. Kind of Business/Industry Private Industry					
	17. Father's Name (First, Middle, Last) Harry Leroy Becker			18. Mother's Name (First, Middle, Maiden Surname) Dorothy Herson						
	19a. Informant's Name/Relationship (Type, Print) Elizabeth Villa/niece		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5606 St. Albans Way, Baltimore, MD 21212							
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery	Date 02-25-2012	20c. Location - City or Town, State Suitland, Maryland				
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Cedar Hill FH, 4111 PA Ave., Suitland, MD 20746						
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Myocardial infarction							Approximate Interval Between Onset and Death Minutes		
	b. Due to (or as a consequence of): Coronary artery disease							Years		
	c. Due to (or as a consequence of):									
	d. Due to (or as a consequence of):									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. dementia							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> A resu Red tiv. j Facility							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred				
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number DS8303							
	29b. Signature and title of certifier 		29d. Date signed (Month, Day, Year) February 22 2012							
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Arlene J Claxton 6701 N. Charles St Towson MD									
State Registrar	31. Date filed (Month, Day, Year) MAR 13 2012		32. Registrar's Signature 							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07693

1 - For
State
Registrar

Physician/
Medical
Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month MARCH Day 11 Year 2012	3. Time of Death 08:12AM
--	--	-----------------------------

BEVERLY

CAPLAN

4a. Facility Name (if not institution, give street and number)

GILCHRIST HOSPICE CARE

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number 220-24-5243	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) 08/29/1929	9. Birthplace (State or Foreign Country) MD
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Usual Residence of Decedent

10a. State MD	10b. County N/A	10c. City, Town or Location BALTIMORE	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
-------------------------	---------------------------	---	--

10e. Street and Number

6300 RED CEDAR PLACE, #204

10f. Zip Code

21209

10g. Citizen of What Country?

USA

11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: WHITE
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15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 2	16b. Kind of Business/Industry BOOKKEEPER
---	---	---

17. Father's Name (First, Middle, Last) NATHAN	18. Mother's Name (First, Middle, Maiden Surname) GOLDSMITH RUTH COHEN
--	--

19a. Informant's Name/Relationship (Type, Print) ROCHELLE COHEN / DAUGHTER	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3902 THOROUGHBRED LANE, OWINGS MILLS, MD 21117
--	--

20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) HEBREW YOUNG MENS	Date 03/12/2012	20c. Location - City or Town, State WOODLAWN, MD
---	--	---------------------------	--

21. Signature of Funeral Service Licensee 	22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208
--	--

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	Approximate Interval Between Onset and Death Unknown
a. Due to (or as a consequence of): <i>Metastatic breast cancer</i>	
b. Due to (or as a consequence of):	
c. Due to (or as a consequence of):	
d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
--	---	---

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
--	--

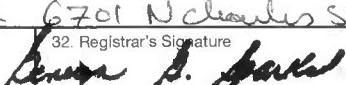
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
---	---

25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice
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27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide	28a. Date of injury (Month, Day, Year) MD	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)			

29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	29c. License number D 71040	29d. Date signed (Month, Day, Year) 3 / 11 / 12
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) APATHI KUMAR 6701 N Charles St Suite 4105 Baltimore MD

31. Date filed (Month, Day, Year) MAR 13 2012	32. Registrar's Signature 
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Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

Within 24 hours after death.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07694

1 - For
State
RegistrarPhysician/
Medical
ExaminerFuneral
Director

Curn Nancy
 Baltimore, Maryland 21215-0036

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

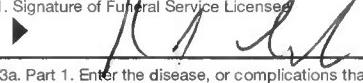
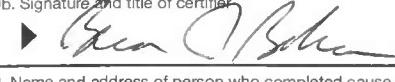
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit one.

State
Registrar

Medical Certificate: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death 2:11 p m
Nancy P. Curry		March 08 2012		
4a. Facility Name (if not institution, give street and number) Greater Baltimore Medical Center		4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore
5. Social Security Number 215-30-2406		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 80 Yrs.	If Under 1 Year Months Days Hours Min.
8. Date of Birth (Month, Day, Year) Nov. 11, 1931		9. Birthplace (State or Foreign Country) Maryland		
10a. State MD.		10b. County Baltimore	10c. City, Town or Location Towson	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
10e. Street and Number 204 E. Joppa Rd. #910		10f. Zip Code 21286		10g. Citizen of What Country? USA
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) +1 Homemaker		16b. Kind of Business/Industry Own Home
17. Father's Name (First, Middle, Last) Bertram Phelps		18. Mother's Name (First, Middle, Maiden Surname) Agnes Dulin		
19a. Informant's Name/Relationship (Type, Print) Eric G. Curry, Sr./ Husband		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 204 E. Joppa Rd. #910 Towson, MD. 21286		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Mem.		20c. Date 3-12-12
20d. Location - City or Town, State Timonium, MD.				
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, md. 21204		
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death 1 day
23c. If female: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number DOO 43483		29d. Date signed (Month, Day, Year) 3/9/12
29b. Signature and title of certifier 				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6535 N-Charles St		32. Registrar's Signature 		
31. Date filed (Month, Day, Year) MAR 13 2012		32. Registrar's Signature		

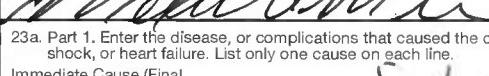
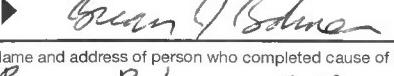
ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 201207695

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) Eleanor Hall Converso				2. Date of Death Month March Day 8 , Year 2012		3. Time of Death 4:45 P M	
Funeral Director		4a. Facility Name (if not institution, give street and number) Greater Baltimore Medical Center				4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore	
To Be Completed by Funeral Director		5. Social Security Number 218-22-8455		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) 11/5/1926	9. Birthplace (State or Foreign Country) Maryland
		Usual Residence of Decedent Maryland Baltimore		10a. State Maryland 10b. County Baltimore				10c. City, Town or Location Lutherville	
		10e. Street and Number 109 Greenridge Road				10f. Zip Code 21093		10g. Citizen of What Country? U.S.A.	
		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Administrator		16b. Kind of Business/Industry Board Of Education	
		17. Father's Name (First, Middle, Last) Frederick M. Hall				18. Mother's Name (First, Middle, Maiden Surname) Olga Schmidt			
		19a. Informant's Name/Relationship (Type, Print) J. Scott Jordan / son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 421 Oak Lane Towson, Maryland 21286			
		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Mem.		Date 3/12/2012	20c. Location - City or Town, State Timonium, Maryland		
		21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204			
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Subdural hematoma							
		Approximate Interval Between Onset and Death 1 day							
		b. Due to (or as a consequence of): Fall							
		Approximate Interval Between Onset and Death 7 days							
		c. Due to (or as a consequence of): Approved							
		d. Due to (or as a consequence of): Approved Deputy							
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year	
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I							
		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
		25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
		27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide							
		28a. Date of injury (Month, Day, Year) 2/29/12 28b. Time of injury 9P M 28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how injury occurred Fell at home making bed							
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) home 28f. Location (Street and Number or Rural Route Number, City or Town, State) 109 Greenridge Rd. Lutherville MD 21093							
		29a. Certifier <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
		29b. Signature and title of certifier 				29c. License number D0043489		29d. Date signed (Month, Day, Year) 3/19/12	
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Brian Bohner MD 6535 N. Charles St. Towson MD 21204							
State Registrar		31. Date filed (Month, Day, Year) MAR 13 2012		32. Registrar's Signature 					

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07696

1- For
State
Registrar

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Daniel Joseph Dolan	MARCH 11, 2012	4:30 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
LORIEN	BELAIR	HARFORD

Funeral
Director

5. Social Security Number	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs.	If Under 1 Year Months Days Hours Min.	If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country) Maryland
213-28-8103		82		Dec. 4, 1929	

Usual Residence of Decedent
Important: If item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at
Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

To Be Completed by Funeral Director

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
Maryland	Harford	Bel Air	

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1909 Emmorton Road	21015	U.S.A.

11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1951-53	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: White
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15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 years	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Foreman	16b. Kind of Business/Industry B & O Railroad
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17. Father's Name (First, Middle, Last) Daniel Vincent Dolan	18. Mother's Name (First, Middle, Maiden Surname) Mary Bertha Welch
---	--

19a. Informant's Name/Relationship (Type, Print) Tracy D. Mangione (daughter)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1208 Meadowlark Dr. Towson, Maryland 21286
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20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest Vet. Cem.	Date	20c. Location - City or Town, State Owings Mills, Maryland
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21. Signature of Funeral Service Licensee <i>D. Joseph Ferran</i>	22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21212
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23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	Approximate Interval Between Onset and Death
a. DEMENTIA, END STAGE Due to (or as a consequence of):	
b. _____ Due to (or as a consequence of):	
c. _____ Due to (or as a consequence of):	
d. _____	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION, DIABETES MELLITUS, PULMONARY EMBOLISM, PARKINSON'S disease, DYSLIPIDEMIA CVA	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
---	--

25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	23f. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
---	---	--

27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
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28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
--	--

29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29c. License number D45344	29d. Date signed (Month, Day, Year) 03/12/2012
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29b. Signature and title of certifier <i>Suresh Dhanjani MD</i>	29c. License number D45344	29d. Date signed (Month, Day, Year) 03/12/2012
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SURESHP DHANJANI MD 622 S. UNION AVE, HAVRE DE GRACE, MD 21028
--

31. Date filed (Month, Day, Year) MAR 13 2012	32. Registrar's Signature <i>Leanne B. Farrel</i>
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Daniel Dolan
Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07697

1- For
State
Registrar

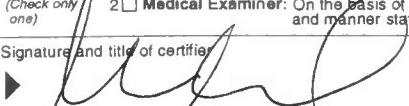
Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 2a & 1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month 3 Day 10 Year 12		3. Time of Death 0013 AM
Valerie Dukes		4b. City, Town, or Location of Death Baltimore, MD		4c. County of Death Baltimore City
4a. Facility Name (If not institution, give street and number) Bon Secours Baltimore		4d. If Under 1 Year Months 0 Days 0 Hours 0 Min. 0		8. Date of Birth Month Day Year 9-9-1966
5. Social Security Number 212-80-1916		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 45 Yrs.
8. Usual Residence of Decedent MD Howard		10a. State MD		10b. County Howard
10c. City, Town or Location Columbia		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 5968 Turnabout Lane Apt. 1		10f. Zip Code 21044		10g. Citizen of What Country? USA
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 4 years Administrative Coordinator John Hopkins University		14. Race - American Indian, Black, White, etc. Specify: Black
17. Father's Name (First, Middle, Last) Leroy Mayo Sr		18. Mother's Name (First, Middle, Maiden Surname) Irma Miller		
19a. Informant's Name/Relationship (Type, Print) Danielle Holman Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5968 Turnabout Lane Apt. 1 MD 21044		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) King Memorial Park 3/17/2012 Baltimore, MD		Date
21. Signature of Funeral Service Licensee Kathy Moissi		22. Name and Address of Facility Vaughn C. Greene Funeral Services 4905 YORK Rd BALTO. MD 21222		20c. Location - City or Town, State
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of death, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				
Immediate Cause (Final disease or condition resulting in death) CVA				
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. _____				
Approximate Interval Between Onset and Death				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
29b. Signature and title of certifier 		29c. License number D65350		29d. Date signed (Month, Day, Year) 3/10/12
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael Doff, MD 2000 W. Baltimore St, Baltimore, MD				
31. Date filed (Month, Day, Year) MAR 13 2012		32. Registrar's Signature Suzanne S. Parker		

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit document.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07698

1 - For
State
Registrar

Physician/
Medical
Examiner

Baltimore, Maryland 21215-0036
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760
To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year			3. Time of Death	
George Bernard Dillmann		March 7, 2012			8:13pm M	
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death			4c. County of Death	
Dove House		Westminster			Carroll	
5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-20-6039		1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	86 Yrs.		Sept 16, 1925	MD
Usual Residence of Decedent					10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10a. State	10b. County	10c. City, Town or Location				
MD	Carroll	Hampstead				
10e. Street and Number		10f. Zip Code			10g. Citizen of What Country?	
4474 Woodsman Drive, Unit 911		21074			USA	
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced						
15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business/Industry	
Elementary/Secondary (0-12) 12		College (1-4 or 5+) Plumber			Plumbing	
17. Father's Name (First, Middle, Last)				18. Mother's Name (First, Middle, Maiden Surname)		
Unknown				Unknown		
19a. Informant's Name/Relationship (Type, Print)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
Betty Lou Dillmann Wife			4474 Woodsman Drive, Unit 911, Hampstead, MD 21074			
20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)			Date	20c. Location - City or Town, State
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		Evergreen Mem. Gard			3/12/12	Finksburg, MD
21. Signature of Funeral Service Licensee		22. Name and Address of Facility			11824 Reisterstown Road	
<i>Stephen M Jenkins</i>		Eline Funeral Home			Reisterstown, MD 21136	
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.						
Immediate Cause (Final disease or condition resulting in death)						
23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown						
23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____						
23d. Date of delivery Month Day Year						
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown						
23f. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						
23g. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <i>Dove House</i>				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Suicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred <i>House</i>
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
29b. Signature and title of certifier <i>J. Dimento</i>		29c. License number <i>DO 071740</i>		29d. Date signed (Month, Day, Year) <i>3/8/12</i>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>DR J. Dimento 555 Center St Westminster, MD 21157</i>						
31. Date filed (Month, Day, Year) <i>MAR 13 2012</i>		32. Registrar's Signature <i>Suzanne S. Paula</i>				

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07699

1 - For
State
Registrar

Physician/
Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

MARCH 11, 2012 6:45 a.m.

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

CHARLES DePETRIS
Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Medical Certificate: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Charles J. DePetris							2. Date of Death Month March Day 11 , Year 2012	3. Time of Death 6:45 A M
4a. Facility Name (if not institution, give street and number) Stella Maris							4b. City, Town, or Location of Death Timonium	4c. County of Death Baltimore
5. Social Security Number 212-07-6033 Usual Residence of Decedent		6. Sex <input checked="" type="checkbox"/> XM <input type="checkbox"/> F	7. Age (In yrs. last birthday) 92 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 6/14/1919	9. Birthplace (State or Foreign Country) Maryland	
10a. State Maryland	10b. County N/A	10c. City, Town or Location Baltimore					10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 2503 E. Strathmore Ave.				10f. Zip Code 21214			10g. Citizen of What Country? U.S.A.	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Sales Rep.				16b. Kind of Business/Industry Furniture	
17. Father's Name (First, Middle, Last) Theodore DePetris					18. Mother's Name (First, Middle, Maiden Surname) Viola Bowley			
19a. Informant's Name/Relationship (Type, Print) Jerry DePetris / Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1701 Providence Road Towson, Maryland 21286				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Mem.			Date 3/14/2012	20c. Location - City or Town, State Timonium, Maryland
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204			

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Severely list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death			
<p>a. CHRONIC OBSTRUCTIVE PULMONARY DISEASE Due to (or as a consequence of):</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____				
23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) HOSPICE			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input checked="" type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	29c. License number R149792			29d. Date signed (Month, Day, Year) 3/12/2012
29b. Signature and title of certifier 				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093				
31. Date filed (Month, Day, Year) MAR 13 2012	32. Registrar's Signature 			

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2012 07700

Certificate of Death

Reg. No.

1- For State
Registrar**Physician/
Medical Examiner**

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death 1454 hrs
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Walter Murray Donaldson

March 8, 2012

1454 hrs

4a. Facility Name (if not institution, give street and number) HMH ER	4b. City, Town, or Location of Death Aberdeen	4c. County of Death Harford
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**Funeral
Director**

5. Social Security Number Unk	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 41 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (MM/DD/YYYY) 11/17/1970	9. Birthplace (State or Foreign Country) MD
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Usual Residence of Decedent

10a. State MD	10b. County Harford	10c. City, Town or Location Aberdeen	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
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10e. Street and Number 10 W. Aztec St.	10f. Zip Code 21001	10g. Citizen of What Country? USA
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11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year of Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No specify:	14. Race - American Indian, Black, White, etc. Specify: White
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15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Brick Layer	16b. Kind of Business/Industry Stone Masonry
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17. Father's Name (First, Middle, Last) Gordon Donaldson, Sr.	18. Mother's Name (First, Middle, Maiden Surname) Marlene May Hahn
--	---

19a. Informant's Name/Relationship (Type, Print) Gary Donaldson/Brother	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 W. Aztec St. Aberdeen, MD 21001
--	--

20a. Method of Disposition 1 <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation <input type="checkbox"/> Other Specify:	20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crem.	Date Mar. 13, 2012	20c. Location - City or Town, State Beltsville, MD
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21. Signature of Funeral Service Licensee Rebecca Rockerman	22. Name and Address of Facility CAFA/Stephen D. Lohrmann P.A. 8717 Green Pastures Dr. Balto, MD 21286
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23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and Death
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Immediate Cause (Final disease or condition resulting in death) **a. Cardiomegaly**
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

<input checked="" type="checkbox"/> UNPENDED	<input type="checkbox"/> AMENDED 23a, 27, per me, g926 4-12-12 sm
--	---

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
--	--

23f. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
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25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other:
---	--

27. Manner of Death 1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work? 1 <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
--	--	---------------------	--	-----------------------------------

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
--	--

29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
--

29b. Signature and title of certifier Zabiullah Ali, M.D.	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) March 11, 2012
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30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

31. Date filed (Month, Day, Year) MAR 13 2012	32. Registrar's Signature Suzanne D. Parker
--	--

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For
State
Registrar

Certificate of Death

Reg. No. **2012 07701**

**Physician/
Medical
Examiner**

**Funeral
Director**

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

1. Decedent's Name (First, Middle, Last) Joseph N. Edmonds			2. Date of Death Month March Day 11 Year 2012			3. Time of Death 10:50 P.M.			
4a. Facility Name (if not institution, give street and number) Citizens Care & Rehabilitation Center			4b. City, Town, or Location of Death Frederick			4c. County of Death Frederick			
5. Social Security Number 577-44-0875		6. Sex 1 M 2 F		7. Age (In yrs. last birthday) 80 Yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 12/18/1931	9. Birthplace (State or Foreign Country) Washington, DC
10a. State MD		10b. County Frederick		10c. City, Town or Location Frederick					10d. Inside City Limits 1 Yes 2 No
10e. Street and Number 355 Montevue Lane			10f. Zip Code 21702			10g. Citizen of What Country? U.S.A.			
11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: White			14. Race - American Indian, Black, White, etc. Specify:	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cab Driver			16b. Kind of Business/Industry Transportation			
17. Father's Name (First, Middle, Last) Hugh Edmonds				18. Mother's Name (First, Middle, Maiden Surname) Virginia Miller					
19a. Informant's Name/Relationship (Type, Print) Bonny Edmonds / Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7217 Beechtree Drive, Middletown, MD 21769					
20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Anatomy Gifts Registry			Date 03/13/2012	20c. Location - City or Town, State Hanover, Maryland		
21. Signature of Funeral Service Licensee BOE			22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076						

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Metastatic Lesions to Brain			Approximate Interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. Due to (or as a consequence of):			
		b. Due to (or as a consequence of):			
		c. Due to (or as a consequence of):			
		d. Due to (or as a consequence of):			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown			23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
25. Was case referred to medical examiner? 1 Yes 2 No		26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)			24a. Was an autopsy performed? 1 Yes 2 No
27. Manner of Death 1 Natural 5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 Yes 2 No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier S. J. Edmonds MD		29c. License number D58391			29d. Date signed (Month, Day, Year) 3-12-12
30. Name and address of person who completed cause of death (item 23a) (Type, Print) SAJJAD AZIZ, MD - 801 Tollhouse Ave, Frederick, MD 21701					
31. Date filed (Month, Day, Year) MAR 13 2012		32. Registrar's Signature Leanne B. Parker			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend 75, 19 & 19a Per FH G925 3/20/2012 JH

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07702

1 - For
State
Registrar

1. Decedent's Name (First, Middle, Last)

Roland Eugene Forster, Sr.

2. Date of Death

Month

Day

Year

3. Time of Death

1:47 PM

Physician/
Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Permit: Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Roland Eugene Forster, Sr.				2. Date of Death Month March Day 07 , Year 2012	3. Time of Death 1:47 PM		
Funeral Director	4a. Facility Name (If not institution, give street and number) Upper Chesapeake Medical Center			4b. City, Town, or Location of Death Bel Air		4c. County of Death Harford		
	5. Social Security Number 0538 218-18-0508	6. Sex 1 M	7. Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sept. 01, 1925		
	Usual Residence of Decedent Maryland Harford			9. Birthplace (State or Foreign Country) Baltimore Maryland				
	10a. State Maryland			10b. County Harford				
	10c. City, Town or Location Bel Air			10d. Inside City Limits 1 Yes 2 No				
	10e. Street and Number 117 Nichols St. Unit F			10f. Zip Code 21014		10g. Citizen of What Country? U.S.A.		
	11. Marital Status 1 Never Married 2 Married		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates. 1944 1945		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Electronic Technician - APG		16b. Kind of Business/Industry Government			
	17. Father's Name (First, Middle, Last) Forster Edward Foster			18. Mother's Name (First, Middle, Maiden Surname) Blanche Swanner				
	19a. Informant's Name/Relationship (Type, Print) Forster Mrs. Shirley Foster (Wife)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 117 Nichols St. Unit F. Bel Air, Maryland 21014				
	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State			20b. Place of Disposition (Name of cemetery, crematory or other place) Evans Funeral Chapel Bel Air	Date March 08, 2012	20c. Location - City or Town, State Forest Hill, Maryland		
	21. Signature of Funeral Service Licensee Jeffrey R. Testerman (M01543)			22. Name and Address of Facility Evans Funeral Chapel & Cremation Services - Bel Air 3 Newport Drive, Forest Hill, Maryland 21050				
Physician/ Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Respiratory Failure			Approximate Interval Between Onset and Death 2 days				
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	{ a. Due to (or as a consequence of): Debility b. Due to (or as a consequence of): Failure to thrive c. Due to (or as a consequence of): d. _____							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown			23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown			23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown				
							24a. Was an autopsy performed? 1 Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
	25. Was case referred to medical examiner? 1 Yes 2 No			26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)				
	27. Manner of Death 1 Natural 5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide			28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 Yes 2 No	28d. Describe how injury occurred	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier [Signature]			29c. License number H0062765	29d. Date signed (Month, Day, Year) 3/7/2012
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nesreen Kortom 500 Upper Chesapeake Drive Bel Air, MD 21014			31. Date filed (Month, Day, Year) MAR 13 2012			32. Registrar's Signature [Signature]	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

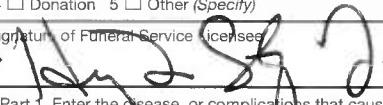
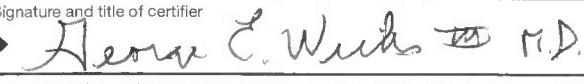
Certificate of Death

Reg. No.

2012 07703

1- For
State
Registrar

Physician/
Medical
Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death	
George E. Floyd Sr.		Month Day Year		11:25 P.M.	
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death	
Baltimore Washington Medical Center		Glen Burnie		Anne Arundel	
5. Social Security Number		6. Sex		7. Age (In yrs. last birthday)	
142-36-4054		1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		If Under 1 Year Months Days Hours Min.	
Usual Residence of Decedent		67 Yrs.		8. Date of Birth (Month, Day, Year)	
10a. State		10b. County		9. Birthplace (State or Foreign Country)	
Maryland		Anne Arundel		NJ	
10c. City, Town or Location		10f. Zip Code		10d. Inside City Limits	
Glen Burnie		21060		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number		10g. Citizen of What Country?			
361 Dublin Drive		USA			
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates.		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry	
Elementary/Secondary (0-12) 9		College (1-4 or 5+) Mechanic		Auto	
17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)			
Norman Nelson Floyd		Helen Unknown			
19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
Juanita Floyd (spouse)		361 Dublin Drive, Glen Burnie, MD 21060			
20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date	20c. Location - City or Town, State
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		Metro Crematory Inc.		March 12 2012	Baltimore, Maryland
21. Signature of Funeral Service Licensee		22. Name and Address of Facility			
		Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death			
<p>a. <u>Disseminated Intravascular Coagulation</u> Due to (or as a consequence of): <u>Pancreatic Cancer</u></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. </p>					
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <u>D41365</u>		29d. Date signed (Month, Day, Year) <u>March 6, 2012</u>	
29b. Signature and title of certifier 					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		31. Date filed (Month, Day, Year) <u>MAR 13 2012</u>		32. Registrar's Signature 	

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

X

X

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Physician/
Medical
Examiner1 - For
State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07704

Funeral
Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) BOOKER			2. Date of Death Month 3 Day 11 Year 2012		3. Time of Death 450p M
4a. Facility Name (if not institution, give street and number) Independence Court			4b. City, Town, or Location of Death Hyattsville		4c. County of Death Prince George's
5. Social Security Number 579-26-6386		6. Sex 1 X M 2 F	7. Age (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days Hours Min.	
8. Date of Birth (Month, Day, Year) 5/03/1926		9. Birthplace (State or Foreign Country) DC		10d. Inside City Limits 1 X Yes 2 No	
10a. State DC			10b. County Washington		
10e. Street and Number 3604 Park Pl NW			10f. Zip Code 20010		10g. Citizen of What Country? USA
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1945- 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates. 1949		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sr. Personnel Specialist		16b. Kind of Business/Industry Department of Army	
17. Father's Name (First, Middle, Last) Booker T. Floyd Sr.			18. Mother's Name (First, Middle, Maiden Surname) Mary Elizabeth Gallmon		
19a. Informant's Name/Relationship (Type, Print) Jerrold Floyd/son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9902 51st Terrace College Park, MD 20740		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) Jmt C. Ingleman			20b. Place of Disposition (Name of cemetery, crematory or other place) Quantico Nat'l Cem.		Date 3-19-2012
21. Signature of Funeral Service Licensee Jmt C. Ingleman			22. Name and Address of Facility Marshall-March Funeral Home 4217 9th ST NW Washington, DC 20011		

Medical Certificate: To Be Completed by Physician/Medical Examiner

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Hypertensive Heart Disease		Approximate Interval Between Onset and Death		
b. Essential Hypertension Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Parkinson's Disease Alzheimer Disease			23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year) 28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29d. Date signed (Month, Day, Year) 3/12/12	
29b. Signature and title of certifier Daniel Oliver, MD			29c. License number MD25847	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James Oliver, MD 5422 1st PL NW Washington, DC 20011				
31. Date filed (Month, Day, Year) MAR 13 2012		32. Registrar's Signature Leanne S. Parker		

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07705

1 - For
State
Registrar

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) Dolly Frank				2. Date of Death Month March Day 10 , Year 2012		3. Time of Death 8:02am M	
Funeral Director		4a. Facility Name (if not institution, give street and number) The Dove House				4b. City, Town, or Location of Death Westminster		4c. County of Death Carroll	
To Be Completed by Funeral Director		5. Social Security Number 220-22-4352		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) 85 Yrs.	If Under 1 Year Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min.	8. Date of Birth (Month, Day, Year) Aug. 9, 1926	9. Birthplace (State or Foreign Country) MD	
		10a. State MD	10b. County Carroll	10c. City, Town or Location Finksburg				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		10e. Street and Number 2261 Old Westminster Pike				10f. Zip Code 21048		10g. Citizen of What Country? United States	
		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Registered Nurse		16b. Kind of Business/Industry Hospital	
		17. Father's Name (First, Middle, Last) Walter Rowe Gilbert				18. Mother's Name (First, Middle, Maiden Surname) Pearl Irene Zeller			
		19a. Informant's Name/Relationship (Type, Print) James W. Frank, Sr (husband)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2261 Old Westminster Pike Finksburg, MD 21048			
		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Druid Ridge Cem.		Date 3-14-2012	20c. Location - City or Town, State Pikesville, MD		
		21. Signature of Funeral Service Licensee 		22. Name and Address of Facility ELINE FUNERAL HOME		11824 Reisterstown Rd. Reisterstown, MD 21136			
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
		<p>a. Lower Respiratory Pneumonia Due to (or as a consequence of):</p> <p>b. Congestive Heart Failure Due to (or as a consequence of):</p> <p>c. Severe Tricuspid Regurgitation Due to (or as a consequence of):</p> <p>d.</p>							
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. COPD Encephalitis, Severe Pulmonary HTN Dementia							
		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
		<p>24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>							
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Dove House					
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number D37449				29d. Date signed (Month, Day, Year) March 12th 2012	
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alexander Bogdashevsky MD, Robert Irene Senter 201 Westminster							
		31. Date filed (Month, Day, Year) MAR 13 2012		32. Registrar's Signature Laura S. Parks					

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

X

X

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #28e Per ME G925 3/13/2012 Jh

State of Maryland / Department of Health and Mental Hygiene

1- For State amend item 27 per me g925 3-22-12 yr
Registrar

Certificate of Death

Reg. No.

2012 07706

Physician/
Medical
Examiner

Funeral
Director

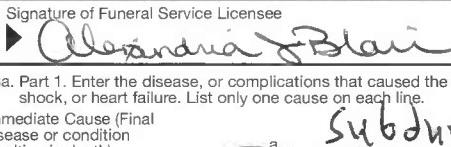
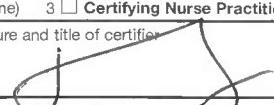
To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. Decedent's Name (First, Middle, Last)				Giel		2. Date of Death	3. Time of Death	
Doris						Month March	Year 2012	
4a. Facility Name (if not institution, give street and number)				Baltimore City		4c. County of Death		
The Johns Hopkins Hospital						N/A		
5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign Country)	
216-16-1159		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	89 Yrs.	Months	Days	(Month, Day, Year) 03/22/1922	MD	
Usual Residence of Decedent		10a. State MD 10b. County N/A 10c. City, Town or Location Baltimore						10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
10e. Street and Number				10f. Zip Code		10g. Citizen of What Country?		
600 Light Street Apt. 731				21230		U.S.A.		
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced								
15. Decedent's Education (Specify only highest grade completed)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business/Industry	
Elementary/Secondary (0-12) 8		College (1-4 or 5+)		Home Maker			Own Home	
17. Father's Name (First, Middle, Last)				18. Mother's Name (First, Middle, Maiden Surname)				
LeRoy T. Meads				Barbara Hlavin				
19a. Informant's Name/Relationship (Type, Print)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)				
Lee Meads, Nephew				5042 Kemp Road, Reisterstown, MD 21136				
20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date	20c. Location - City or Town, State			
1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) Entombment		Most Holy Redeemer		03/12/2012	Baltimore, MD			
21. Signature of Funeral Service Licensee		22. Name and Address of Facility						
		Leonard J. Ruck, Inc. 5305 Harford Road, Baltimore, MD 21214						
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
Immediate Cause (Final disease or condition resulting in death)								
Subdural Hematoma								
Approximate Interval Between Onset and Death								
<p>a. Due to (or as a consequence of):</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p> <p><i>[Handwritten note: CERTIFICATION APPROVED BY MEDICAL EXAMINER]</i></p>								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year) 3/1/2012		28b. Time of injury unknown	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	28d. Describe how injury occurred Subject fell		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 600 Light Street		Residence		28f. Location (Street and Number or Rural Route Number, City or Town, State) 600 Light St Baltimore, MD		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 		29c. License number		29d. Date signed (Month, Day, Year)				
		RES-600		March 7, 2012				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		600 North Wolfe St, Baltimore, MD 21287						
Jennifer Cheng		600 North Wolfe St, Baltimore, MD 21287						
31. Date filed (Month, Day, Year)		32. Registrar's Signature						
MAR 13 2012								

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07707

1- For
State
RegistrarPhysician/
Medical
Examiner

1. Decedent's Name (First, Middle, Last) SEYMORE GOLODNER		2. Date of Death Month MARCH Day 09 Year 2012	3. Time of Death 07:55P M		
4a. Facility Name (if not institution, give street and number) GILCHRIST HOSPICE CARE		4b. City, Town, or Location of Death TOWSON	4c. County of Death BALTIMORE		
5. Social Security Number 221-18-4725		6. Sex 1 X M 2 □ F	7. Age (In yrs. last birthday) 82 Yrs.		
8. Date of Birth (Month, Day, Year) 10/11/1929		9. Birthplace (State or Foreign Country) NY	10. Usual Residence of Decedent		
10a. State MD	10b. County BALTIMORE	10c. City, Town or Location PARKVILLE			
10e. Street and Number 8800 WALTHER BLVD		10f. Zip Code 21234	10g. Citizen of What Country? USA		
11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 X Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 X No Specify:	14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 4 ACCOUNTANT	16b. Kind of Business/Industry FEDERAL GOVERNMENT		
17. Father's Name (First, Middle, Last) JOSEPH		18. Mother's Name (First, Middle, Maiden Surname) GOLDBERG BESSIE	YAMPOLSKY		
19a. Informant's Name/Relationship (Type, Print) JILL IONTA / DAUGHTER		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1120 OVERBROOK ROAD, BALTIMORE, MD 21239			
20a. Method of Disposition 1 □ Burial 2 X Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) HILLTOP SERVICE, CORP.	Date 03/12/2012		
21. Signature of Funeral Service Licensee ► Max Le —		22. Name and Address of Facility SOL LEVINSON & BROS., INC.			
		8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208			
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)					
a. Acute Stroke Due to (or as a consequence of):					
b. Atrial Fibrillation Due to (or as a consequence of):					
c. Congestive Heart Failure Due to (or as a consequence of):					
d.					
Approximate Interval Between Onset and Death days					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		23c. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (Specify) 9 □ Unknown			
23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
		23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 □ Probably 4 X Unknown			
		24a. Was an autopsy performed? 1 □ Yes 2 X No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No		
25. Was case referred to medical examiner? 1 □ Yes 2 X No		26. Place of Death (Check only one) Hospital: 1 □ Inpatient 2 □ ER/Outpatient 3 □ DCA Other: 4 □ Nursing Home 5 □ Residence 6 X Other (Specify) Hospice			
27. Manner of Death 1 X Natural 5 □ Pending Investigation 2 □ Accident 6 □ Could not be determined 3 □ Suicide 4 □ Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 □ Yes 2 □ No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 □ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier ► Schatz		29c. License number D 71040		29d. Date signed (Month, Day, Year) 3/10/12	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARATHI KUMAR 6701 N Charles St Suite 6105 BALTIMORE MD					
31. Date filed (Month, Day, Year) MAR 13 2012		32. Registrar's Signature Caron J. Pace			

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

F

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07708

1 - For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) RIVALIA GORELIK						2. Date of Death Month MARCH Day 8 Year 2012		3. Time of Death 740 AM					
	4a. Facility Name (if not institution, give street and number) NORTHWEST			4b. City, Town, or Location of Death RANDALLSTOWN			4c. County of Death BALTIMORE							
Funeral Director	5. Social Security Number 218-35-0976	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) 05/05/1921	9. Birthplace (State or Foreign Country) UKRAINE							
To Be Completed by Funeral Director	10a. State MD 10b. County BALTIMORE 10c. City, Town or Location OWINGS MILLS						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	10e. Street and Number 3410 ASSOCIATED WAY, #424			10f. Zip Code 21117			10g. Citizen of What Country? USA							
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE						
	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) 4			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) NURSE			16b. Kind of Business Industry NURSING							
	17. Father's Name (First, Middle, Last) ARON FEINGOLD			18. Mother's Name (First, Middle, Maiden Surname) PASE ZIFERBLATT										
	19a. Informant's Name/Relationship (Type, Print) LUDMILA GORELIK/DAUGHTER			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 913 RACHEL JORDON COURT, OWINGS MILLS, MD 21117										
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) BALTIMORE HEBREW CEM			20b. Place of Disposition (Name of cemetery, crematory or other place) BALTIMORE HEBREW CEM			Date 03/11/2012	20c. Location - City or Town, State REISTERSTOWN, MD						
	21. Signature of Funeral Service Licensee Michael Brugger			22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208										
Physician/ Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE									Approximate Interval Between Onset and Death				
	a. Due to (or as a consequence of): ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE													
	b. Due to (or as a consequence of):													
	c. Due to (or as a consequence of):													
	d. Due to (or as a consequence of):													
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) Unknown			23d. Date of delivery Month Day Year							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
										24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
										24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred							
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
	29b. Signature and title of certifier Jeffrey Johnson			29c. License number 00024970			29d. Date signed (Month, Day, Year) MARCH 8, 2012							
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LEFFORD FASER 5401 020 COUNTY ROAD, RANDALLSTOWN, MARYLAND			21133										
	31. Date filed (Month, Day, Year) MAR 13 2012			32. Registrar's Signature James L. Parker										

Baltimore, Maryland 21215-0036

Permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07709

1 - For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) JEFFREY DONALD HEPHNER							2. Date of Death Month MARCH Day 7 Year 2012	3. Time of Death 12:03 A M
	4a. Facility Name (if not institution, give street and number) 20359 Flat Iron Rd.			4b. City, Town, or Location of Death Great Mills			4c. County of Death St. Mary		
Funeral Director	5. Social Security Number 219-86-1917	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 51 Yrs.	If Under 1 Year Months <input type="checkbox"/> Days <input type="checkbox"/>	If Under 24 Hrs. Hours <input type="checkbox"/> Min. <input type="checkbox"/>	8. Date of Birth (Month, Day, Year) Aug. 8, 1960	9. Birthplace (State or Foreign Country) Washington DC		
	Usual Residence of Decedent 10a. State MD 10b. County St. Mary 10c. City, Town or Location Great Mills 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
To Be Completed by Funeral Director	10e. Street and Number 20359 Flat Iron Rd.			10f. Zip Code 20634			10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates -VIETNAM	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. White Specify:					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mover	16b. Kind of Business Industry Quality Moving Co.						
	17. Father's Name (First, Middle, Last) Gary Dobald Hepner	18. Mother's Name (First, Middle, Maiden Surname) Nancy Ann Bossler							
	19a. Informant's Name/Relationship (Type, Print) Jeanene Brinkley/sister	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12999 Rousby Hall Rd. Lusby, Md. 20657							
Physician/ Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Final Journey	20b. Place of Disposition (Name of cemetery, crematory or other place) Final Journey	Date 3/12/12	20c. Location - City or Town, State Woodbine, MD					
Medical Certificate: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Charisse N. Woods F/S	22. Name and Address of Facility 2700 Edmondson Ave. Balt., Md 21223							
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	Approximate Interval Between Onset and Death							
	a. METASTATIC LUNG CANCER Due to (or as a consequence of):								
	b. ADENOCARCINOMA OF THE COLON Due to (or as a consequence of):								
	c. FAMILIAL POLYPPOSIS Due to (or as a consequence of):								
	d. _____								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year						
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
Medical Certificate: To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide	28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred				
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
	29b. Signature and title of certifier JOANNA ROSEN MD	29c. License number MD# 0101227815			29d. Date signed (Month, Day, Year) MARCH 7, 2012				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOANNA BRYNN ROSEN, M.D., VAMC 50 IRVING STREET NW, WASHINGTON, DC 20422/688								
State Registrar	31. Date filed (Month, Day, Year) MAR 13 2012	32. Registrar's Signature <i>Leanne J. Parker</i>							

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

12-02010

Sherard Donald Houston

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07710

1- For State Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Sherard Houston					2. Date of Death Month March Day 10 Year 2012	3. Time of Death 0109 hrs		
Funeral Director	4a. Facility Name (if not institution, give street and number) 1000 East Hoffman Street			4b. City, Town, or Location of Death Baltimore		4c. County of Death			
To Be Completed by Funeral Director	5. Social Security Number 055-58-9996		6. Sex 1 X M	7. Age (In yrs. last birthday) 38 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (MM/DD/YYYY) 7-16-1973	9. Birthplace (State or Foreign Country) NY	
	Usual Residence of Decedent		10a. State MD 10b. County n/a 10c. City, Town or Location Baltimore					10d. Inside City Limits 1 X Yes 2 No	
	10e. Street and Number 1524 E. Fairmount Avenue			10f. Zip Code 21231			10g. Citizen of What Country? USA		
Physician/ Medical Examiner	11. Marital Status 1 <input type="checkbox"/> Never Married 2 X Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 X No		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 X No specify: African-American		14. Race - American Indian, Black, White, etc.		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)			16b. Kind of Business/Industry Security		
	17. Father's Name (First, Middle, Last) Donald Houston				18. Mother's Name (First, Middle, Maiden Surname) Gilda Price				
	19a. Informant's Name/Relationship (Type, Print) Lisa Houston/ Wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1524 E. Fairmount Avenue, Baltimore, MD 21231					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 X Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory		Date 3-13-2012	20c. Location - City or Town, State Baltimore, MD			
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Wylie Funeral Home P.A. of Baltimore Co. 9200 Liberty Road, Randallstown, MD 21133						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line.								
	Approximate Interval Between Onset and Death								
	Immediate Cause (Final disease or condition resulting in death) a. Multiple Gunshot Wounds Due to (or as a consequence of):								
	b. Due to (or as a consequence of):								
	c. Due to (or as a consequence of):								
	d. Due to (or as a consequence of):								
	<input type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown								
	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown								
	23d. Date of delivery Month Day Year								
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
	24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No								
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No								
	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No								
	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene								
	27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide								
	28a. Date of Injury (Month, Day, Year) Mar 10, 2012								
	28b. Time of Injury 0101 hrs								
	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
	28d. Describe how injury occurred Subject shot								
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Sidewalk								
	28f. Location (Street and Number or Rural Route Number, City or Town, State) 1000 East Hoffman Street, Baltimore, Md.								
	29a. Certifier 1 <input type="checkbox"/> Certifying Physician : To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner : On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier 								
	29c. License number O.C.M.E.								
	29d. Date signed (Month, Day, Year) March 10, 2012								
	30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223								
	31. Date filed (Month, Day, Year) MAR 13 2012								
	32. Registrar's Signature 								

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

5pm
State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07711

1 - For
State
Registrar

Physician/
Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/
Medical
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. Decedent's Name (First, Middle, Last)		Martha Lin Holden		2. Date of Death Month Day Year		3. Time of Death Hour Minute AM PM	
4a. Facility Name (if not institution, give street and number)		The Johns Hopkins Hospital		4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
5. Social Security Number 233-82-1782		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 60 Yrs.		If Under 1 Year Months Days Hours Min.	
8. Date of Birth (Month, Day, Year) Feb. 25, 1952		9. Birthplace (State or Foreign Country) Bethesda, MD.		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10a. State Maryland		10b. County Baltimore County		10c. City, Town or Location Timonium			
10e. Street and Number 620 Lavenham Court				10f. Zip Code 21093		10g. Citizen of What Country? United States	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Counselor		16b. Kind of Business/Industry New Song Academy	
17. Father's Name (First, Middle, Last) John Pershing Carr				18. Mother's Name (First, Middle, Maiden Surname) Martha Ferguson			
19a. Informant's Name/Relationship (Type, Print) Mr. Richard Horace Holden, Jr.		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 620 Lavenham Court		19c. Name and Address of Facility Peaceful Alternatives Funeral and Cremation Center, P.A.		19d. Date Tuesday, March 13, 2012	
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) ► Jeffrey L. Gair, Sr. OFSP		20b. Place of Disposition (Name of cemetery, crematory or other place) Evans Funeral Chapel and Cremation Serv. Inc.		20c. Location - City or Town, State (Harford County) Forest Hill, Maryland			
21. Signature of Funeral Service License Jeffrey L. Gair, Sr. OFSP		22. Name and Address of Facility Peaceful Alternatives Funeral and Cremation Center, P.A.		23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Sepsis		24. Approximate Interval Between Onset and Death	
23a. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Coronary Artery Disease		23b. Due to (or as a consequence of): Valvular insufficiency		23c. Due to (or as a consequence of):			
23d. Date of delivery Month Day Year							
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
23f. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		23g. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24h. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		24i. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24j. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24k. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) RES-000		24l. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
24m. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		24n. Date of injury (Month, Day, Year)		24o. Time of injury M		24p. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		24q. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				24r. Describe how injury occurred	
24s. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						24t. Location (Street and Number or Rural Route Number, City or Town, State)	
24u. Signature and title of certifier ► Keki R. Balasa		24v. License number RES-000		24w. Date signed (Month, Day, Year) march.11,2012			
24x. Name and address of person who completed cause of death (Item 23a) (Type, Print) Keki R. Balasa 600 n. Wolfe St Baltimore MD 21287							
24y. Date filed (Month, Day, Year) MAR 13 2012		24z. Registrar's Signature Kenny A. Gair					

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07712

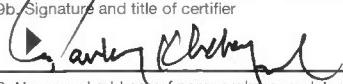
1 - For
State
Registrar

Physician/
Medical
Examiner

Funeral
Director

Baltimore, Maryland 21215-0036
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) Robert C. Hein			2. Date of Death Month March Day 09 , Year 2012	3. Time of Death 5:15 PM
4a. Facility Name (if not institution, give street and number) Manor Care Rossville			4b. City, Town, or Location of Death Rosedale	
4c. County of Death Baltimore				
5. Social Security Number 214-34-3881	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 75 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours Min.
8. Date of Birth (Month, Day, Year) Dec. 11, 1936			9. Birthplace (State or Foreign Country) Maryland	
10a. State MD			10b. County Baltimore	
10c. City, Town or Location Baltimore			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 3045 Arizona Avenue			10f. Zip Code 21234	10g. Citizen of What Country? United States
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerk	
17. Father's Name (First, Middle, Last) Albert Hein			18. Mother's Name (First, Middle, Maiden Surname) Evelyn Martini	
19a. Informant's Name/Relationship (Type, Print) Beverly Merryman-Sister			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3045 Arizona Avenue, Baltimore, MD 21234	
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Memorial Gardens	Date March 13, 2012
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Evans Funeral Chapel & Cremation Services 8800 Harford Rd. Parkville, MD 21234	
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
<p>a. Due to (or as a consequence of): ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>				
Approximate Interval Between Onset and Death				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown	
23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred		
28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. Signature and title of certifier 			29c. License number DOO605-60	
29d. Date signed (Month, Day, Year) MARCH 12, 2012				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PANKAJ KHETPAL 9106, PHILADELPHIA RD #208, ROSEDALE, MD				
31. Date filed (Month, Day, Year) MAR 13 2012			32. Registrar's Signature 	

Division of Vital Records, P.O. Box 68700

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

State
Registrar

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07713

1 - For
State
RegistrarPhysician/
Medical
ExaminerFuneral
Director

Baltimore, Maryland 21215-0036
 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland
 Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
 any injury or other traumatic event, the Medical Examiner must be notified at
 once.

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last)		<i>Clyde Hester</i>		2. Date of Death		3. Time of Death	
				Month	Day	Year	M P M
4a. Facility Name (if not institution, give street and number)		The Johns Hopkins Hospital		4b. City, Town, or Location of Death		4c. County of Death	
				Baltimore City		N/A	
5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign Country)
218-90-5117		1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	47 Yrs.	Months	Days	(Month, Day, Year)	Oct 21, 1964 MD
Usual Residence of Decedent						10d. Inside City Limits	
10a. State	10b. County	10c. City, Town or Location				1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
MD	N/A	Baltimore					
10e. Street and Number		10f. Zip Code		10g. Citizen of What Country?			
1624 Darley Ave		21213		USA			
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)		14. Race - American Indian, Black, White, etc.	
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		Specify: Black	
15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry			
Elementary/Secondary (0-12) 11		Clerk		Coppin State College			
17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)					
Clyde J. Hester		Rosa Cherry					
19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)					
Antionette Price		3531 Lyndale Ave, Baltimore, MD					
20a. Method of Disposition		20b. Place of Disposition (Name of cemetery/crematory or other place)		Date	20c. Location - City or Town, State		
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) <i>Brian J. Howell Jr.</i>		Fairwood		3/15/2012	Baltimore, MD		
21. Signature - Funeral Service License		22. Name and Address of Facility					
		Howell Funeral Home 3331 Brehms Ln, Baltimore, MD					
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death			
		a. Due to (or as a consequence of): <i>ALCOHOL LIVER DISEASE</i>					
		b. Due to (or as a consequence of): <i>HEPATOPULMONARY SYNDROME</i>					
		c. Due to (or as a consequence of):					
		d. Due to (or as a consequence of):					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year			
		3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (specify) _____					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DCA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29b. Signature and title of certifier <i>Blathin McManon</i>		29c. License number <i>REG-000</i>		29d. Date signed (Month, Day, Year) <i>March 9 - 2012</i>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>BLATHIN MC MANON 600 North Wolfe Street Baltimore Maryland</i>							
31. Date filed (Month, Day, Year) <i>MAR 13 2012</i>		32. Registrar's Signature <i>Laura M. Jackson</i>					

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0036

Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland

Department of Health and Mental Hygiene.

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07714

1 - For
State
Registrar

Physician/
Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Division of Vital Records, P.O. Box 68760
Baltimore, Maryland 21244-2958
To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. Decedent's Name (First, Middle, Last)

DOROTHY HELEN HEJL-NEWQUIST

2. Date of Death

Month

Day

Year

FEB. 24, 2012

3. Time of Death

1:30 PM

4a. Facility Name (if not institution, give street and number)

UPPER CHESAPEAKE MEDICAL CENTER

4b. City, Town, or Location of Death

BEL AIR

4c. County of Death

HARFORD

5. Social Security Number

214-38-1425

6. Sex

1 M 2 F

7. Age (In yrs. last birthday)

79

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

8/7/1932

9. Time of Death

10. Usual Residence of Decedent

10a. State

MD

10b. County

HARFORD

10c. City, Town or Location

JOPPA

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

521 ANCHOR DR

10f. Zip Code

21085

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12) 12

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

OFFICE ASSISTANT

16b. Kind of Business/Industry

SOCIAL SERVICES

17. Father's Name (First, Middle, Last)

ALEXANDER MELVILLE

18. Mother's Name (First, Middle, Maiden Surname)

MARTHA TURNER

19a. Informant's Name/Relationship (Type, Print)

ROBERT NEWQUIST-HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

521 ANCHOR DR JOPPA, MD 21085

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

HIGHVIEW MEM. GARDENS

Date

2/27/12

20c. Location - City or Town, State

FALLSTON, MD

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

SCHIMMEL FUNERAL HOME OF BELAIR

610 W. MACPHAIL RD BEL AIR, MD 21014

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death

a. Due to (or is a consequence of):

Congestive heart failure

Acute myocardial infarction

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No
9 Unknown

23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify)
9 Unknown

23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Aspiration pneumonia

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

26. Place of Death (Check only one)

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 5 Pending Investigation
2 Accident 6 Could not be determined
3 Suicide
4 Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D103420

29d. Date signed (Month, Day, Year)

March 12, 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sid Z Kharai 500 Upper Chesapeake Drive Bel Air MD 21014

31. Date filed (Month, Day, Year)

MAR 13 2012

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

2012 07715

Reg. No.

1- For
State
Registrar

Physician/
Medical
Examiner

Funeral
Director

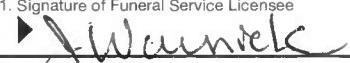
To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036
Hurlock, Dorothy 3/10/12 1120
Division of Vital Records, P.O. Box 68760
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit once.

Physician/
Medical
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit once.

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month MARCH Day 10 , Year 2012				3. Time of Death 11:20 AM	
DOROTHY NETTIE HURLOCK		4b. City, Town, or Location of Death PARKVILLE				4c. County of Death BALTIMORE	
4a. Facility Name (if not institution, give street and number) OAKCREST CARE CENTER		5. Social Security Number 220-14-7669		6. Sex 1 □ M 2 X F	7. Age (in yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days Hours Min.	
8. Usual Residence of Decedent							
10a. State MD		10b. County BALTIMORE		10c. City, Town or Location PARKVILLE			10d. Inside City Limits 1 □ Yes 2 X No
10e. Street and Number 8832 WALTHER BLVD APT 321		10f. Zip Code LARKS LANDING 21234		10g. Citizen of What Country? USA			
11. Marital Status 1 □ Never Married 2 □ Married 3 X Widowed 4 □ Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 X No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 X No Specify:			14. Race - American Indian, Black, White, etc. WHITE Specify:
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 2		16b. Kind of Business/Industry HOWARD COUNTY BOARD OF EDUCATION			
17. Father's Name (First, Middle, Last) HIRAM J. TAYLOR, SR.		18. Mother's Name (First, Middle, Maiden Surname) NELLIE M. BAKER					
19a. Informant's Name/Relationship (Type, Print) WILLIAM HURLOCK, JR.		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2985 ELKRIDGE LANE YORK, PA 17404					
20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) LORRAINE PARK CEM.		Date 3/14/12	20c. Location - City or Town, State BALTIMORE, MD		
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility SCHIMUNEK FUNERAL HOME 9705 BELAIR RD NOTTINGHAM, MD 21236					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hyperensive Cardiovascular Disease		Approximate Interval Between Onset and Death			
23c. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown		23d. Date of delivery Month Day Year					
23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 X No 3 □ Probably 4 □ Unknown		23f. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 X No					
25. Was case referred to medical examiner? 1 □ Yes 2 X No		26. Place of Death (Check only one) Hospital: 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA Other: X Nursing Home 5 □ Residence 6 □ Other (Specify)		27. Manner of Death 1 X Natural 5 □ Pending Investigation 2 □ Accident 6 □ Could not be determined			
28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? 1 □ Yes 2 □ No	28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 □ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number R171944		29d. Date signed (Month, Day, Year) 3/12/12			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michelle G Herring cert 8800 Walther Blvd Parkville MO 21234		31. Date filed (Month, Day, Year) MAR 13 2012		32. Registrar's Signature Janice B. Appling			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
 amend 30, per DMR, g925 3-13-12 sm
 State of Maryland / Department of Health and Mental Hygiene

1 - For
State
Registrar

Certificate of Death

Reg. No.

2012 07716

**Physician/
Medical
Examiner**

**Funeral
Director**

To Be Completed by Funeral Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <i>Joan Hale</i>							2. Date of Death Month <input checked="" type="checkbox"/> 03 Day <input type="checkbox"/> 08 Year <input type="checkbox"/> 2012	3. Time of Death <input type="checkbox"/> 7:40 AM
4a. Facility Name (if not institution, give street and number) <i>Fairhaven</i>							4b. City, Town, or Location of Death <i>Sykesville</i>	4c. County of Death <input checked="" type="checkbox"/> Carroll
5. Social Security Number 219-28-2281		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months <input type="checkbox"/> Days	If Under 24 Hrs. Hours <input type="checkbox"/> Min.	8. Date of Birth (Month, Day, Year) April 18 1928	9. Birthplace (State or Foreign Country) MD	
Usual Residence of Decedent: 10a. State MD 10b. County Carroll 10c. City, Town or Location Sykesville 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
10e. Street and Number 7200 Third Avenue C-45				10f. Zip Code 21784			10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) homemaker		16b. Kind of Business Industry domestic				
17. Father's Name (First, Middle, Last) Carl W. Schmidt				18. Mother's Name (First, Middle, Maiden Surname) Else Melamet				
19a. Informant's Name/Relationship (Type, Print) Mr. Robert W. Hale (spouse)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7200 Third Ave., C-45, Sykesville, MD 21784				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) All County Cremation				20b. Place of Disposition (Name of cemetery, crematory or other place)		Date 3-10-12	20c. Location - City or Town, State Sykesville, MD	
21. Signature of Funeral Service Licensee ►Paige Slought Gerspert				22. Name and Address of Facility Haight Funeral Home & Chapel P.O. Box 195 Sykesville, MD 21784				
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Crohn's disease Approximate Interval Between Onset and Death a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		26. Place of Death (Check only one) <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29c. License number D0059054		29d. Date signed (Month, Day, Year) 3/19/12		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ana Sarante 1645 Liberty Rd. Ste:204 Eldersburg, MD, 21784								
31. Date filed (Month, Day, Year) MAR 13 2012		32. Registrar's Signature <i>Renata J. Park</i>						

**State
Registrar**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 111111111111111111

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) Willie Jackson						2. Date of Death Month 3 - Day 18 - Year 2012	3. Time of Death 12:20 PM				
Funeral Director		4a. Facility Name (if not institution, give street and number) 1237 N. Ellwood Ave			4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A						
To Be Completed by Funeral Director		5. Social Security Number 2116-34-8639		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (in yrs. last birthday) 72 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) March 16, 1939	9. Birthplace (State or Foreign Country) SC				
		Usual Residence of Decedent MD		10a. State MD	10b. County N/A	10c. City, Town or Location Baltimore		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
		10e. Street and Number 1237 N. Ellwood Ave			10f. Zip Code 21213			10g. Citizen of What Country? USA					
		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black					
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Warehouse Supervisor			16b. Kind of Business/Industry Distribution					
		17. Father's Name (First, Middle, Last) unk			18. Mother's Name (First, Middle, Maiden Surname) Lulvert Jackson								
		19a. Informant's Name/Relationship (Type, Print) Wanda Jackson			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1237 N. Ellwood Ave, Baltimore, MD								
		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Oaklawn		Date 3/16/2012	20c. Location - City or Town, State Baltimore, MD					
		21. Signature of Funeral Service Licensee Bruce Howell/SR			22. Name and Address of Facility Howell Funeral Home 3331 Brehms Ln, Baltimore, MD								
Physician/ Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death					
		<p>a. Due to (or as a consequence of): Cholangiocarcinoma</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>											
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year					
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospital			24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of injury (Month, Day, Year) M		28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred				
					28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
		29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
		29b. Signature and title of certifier Dr Karen Covington Brown			29c. License number H0064267			29d. Date signed (Month, Day, Year) 3-11-12					
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr Karen Covington Brown 827 Linden Av. Baltimore MD 21201											
		31. Date filed (Month, Day, Year) MAR 13 2012		32. Registrar's Signature J. Parker									
Division of Vital Records, P.O. Box 68760													
		To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.											
		Physician/Medical Examiner Medical Certificate: To Be Completed by Physician/Medical Examiner											

**State
registrar**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07718

1- For
State
RegistrarPhysician/
Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/
Medical
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

3

1. Decedent's Name (First, Middle, Last) Dorothea J. Jones		2. Date of Death Month March Day 9 Year 2012		3. Time of Death 11:49 a M
4a. Facility Name (if not institution, give street and number) Gilchrist		4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore
5. Social Security Number 158-30-7139		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (in yrs. last birthday) 69 Yrs.	If Under 1 Year Months Days Hours Min.
Usual Residence of Decedent 10a. State MD 10b. County n/a		10c. City, Town or Location Baltimore		
10e. Street and Number 3705 Rexmere Road		10f. Zip Code 21218		10g. Citizen of What Country? U.S.A.
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own home
17. Father's Name (First, Middle, Last) William J. Corbett		18. Mother's Name (First, Middle, Maiden Surname) Frances McDevitt		
19a. Informant's Name/Relationship (Type, Print) Frances C. Stoner-sister		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3705 Rexmere Rd., Baltimore, MD 21218		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lakeview Mem'l Park	Date 3/14/12	20c. Location - City or Town, State Cinnaminson, NJ
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 21204		
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death years		
a. Due to (or as a consequence of): 				
b. Due to (or as a consequence of): 				
c. Due to (or as a consequence of): 				
d. Due to (or as a consequence of): 				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospital		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No
		28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		
29b. Signature and title of certifier 		29c. License number D71040		29d. Date signed (Month, Day, Year) 3/10/12
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) APATHS KUMAR 6701 N CHARLES ST SUITE 1105 BALTIMORE MD				
31. Date filed (Month, Day, Year) MAR 13 2012		32. Registrar's Signature 		

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07719

1- For State Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last)					2. Date of Death Month Day Year	3. Time of Death 1603 hrs
	Kyung Im Kim					March 10, 2012	

4a. Facility Name (if not institution, give street and number)			4b. City, Town, or Location of Death			4c. County of Death	
Baltimore Washington Medical Center			Severn			Anne Arundel	

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth(MM/DD/YYYY)	9. Birthplace (State or Foreign Country)
N/A	1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	83 Yrs.		Hours Min.	Jan 5, 1931	Korea

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
N/A	Chung Ju Si	Chung Cheong Book	

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
N/A	N/A	Korea

11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify:	14. Race - American Indian, Black, White, etc. Specify: Korean
--	---	--	---

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker	16b. Kind of Business/Industry Own Home
---	--	--

17. Father's Name (First, Middle, Last) Jong Min Kim	18. Mother's Name (First, Middle, Maiden Surname) Dol I Jang
---	---

19a. Informant's Name/Relationship (Type, Print) Sun Yoon Whang Son	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1252 Colonial Park Dr., Severn, MD 21144
--	---

20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:	20b. Place of Disposition (Name of cemetery, crematory or other place) Bayview Crematory	Date	20c. Location - City or Town, State March 13, 2013 Baltimore, MD
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21. Signature of Funeral Service Licensee K. Gregory Fink M01148	22. Name and Address of Facility Fink Funeral Home, P.A. 426 Crain Hwy S., Glen Burnie, MD 21061
---	--

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	a. Hypertensive Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):	Approximate interval Between Onset and Death
--	--	--

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last	b. Due to (or as a consequence of):	
---	--	--

c. Due to (or as a consequence of):	d. Due to (or as a consequence of):	
--	--	--

<input type="checkbox"/> UNPENDED	<input checked="" type="checkbox"/> AMENDED #1 as noted, per me, g925 3-13-12 sm	
-----------------------------------	--	--

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) _____ 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
---	---	---

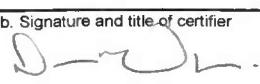
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
--	--

24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
---	--

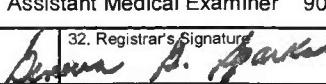
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene
---	---

27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
--	--	---------------------	--	-----------------------------------

				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
--	--	--	--	--	--

29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29b. Signature and title of certifier 	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) March 11, 2012
--	--	---------------------------------	---

30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

31. Date filed (Month, Day, Year) MAR 13 2012	32. Registrar's Signature 
--	--

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 97720

1- For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) William Mitchell Kuzmiak					2. Date of Death Month March Day 11 Year 2012	3. Time of Death 8:38 AM		
	4a. Facility Name (if not institution, give street and number) Stella Maris Hospice					4b. City, Town, or Location of Death Timonium		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 143-03-6281		6. Sex 1 X M 2 □ F	7. Age (In yrs. last birthday) 92 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) March 1, 1920	9. Birthplace (State or Foreign Country) New Jersey	
To Be Completed by Funeral Director	10a. State Maryland		10b. County Baltimore	10c. City, Town or Location Timonium				10d. Inside City Limits 1 □ Yes 2 X No	
	10e. Street and Number 712 W. Timonium Rd.			10f. Zip Code 21093		10g. Citizen of What Country? United States			
	11. Marital Status 1 □ Never Married 2 □ Married 3 X Widowed 4 □ Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates. WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 X No Specify:		14. Race - American Indian, Black, White, etc. Specify: white		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) chief executive officer			16b. Kind of Business/Industry textiles		
	17. Father's Name (First, Middle, Last) William S. Kuzmiak				18. Mother's Name (First, Middle, Maiden Surname) Suzanne Brinsko				
	19a. Informant's Name/Relationship (Type, Print) Douglas Kuzmiak/son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 712 W. Timonium Rd. Timonium, MD 21093					
	20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Mem Gard		Date Mar. 15, 2012	20c. Location - City or Town, State Timonium, Maryland		
	21. Signature of Funeral Service Licensee John O. Mitchell IV			22. Name and Address of Facility John O. Mitchell IV, Funeral Services of Dulaney Valley, 200 E. Padonia Rd. Timonium, MD 21093 P.A.					
Physician/ Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CARDIOMYOPATHY								
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
	23c. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown								
	23d. Date of delivery Month Day Year								
	23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 X No 3 □ Probably 4 □ Unknown								
	24a. Was an autopsy performed? 1 □ Yes 2 X No 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No								
	25. Was case referred to medical examiner? 1 □ Yes 2 X No								
	26. Place of Death (Check only one) Hospital: 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 □ Nursing Home 5 □ Residence 6 X Other (Specify) HOSPICE								
	27. Manner of Death 1 X Natural 5 □ Pending Investigation 2 □ Accident 6 □ Could not be determined 3 □ Suicide 4 □ Homicide								
	28a. Date of injury (Month, Day, Year) 28b. Time of injury M 28c. Injury at work? 1 □ Yes 2 □ No								
	28d. Describe how injury occurred								
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								
	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	29a. Certifier 1 □ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
	29b. Signature and title of certifier JACKIE JONES, CRNP								
	29c. License number R149792								
	29d. Date signed (Month, Day, Year) 3/12/2012								
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093								
	31. Date filed (Month, Day, Year) MAR 13 2012								
	32. Registrar's Signature Leanne B. Parker								

MARCH 11, 2012 8:38 a.m.
Baltimore, Maryland 21215-0036WILLIAM KUZMIAK
Division of Vital Records, P.O. Box 68760To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transitpermit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 0772

1- For
State
Registrar

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) CHANG Y KIM

2. Date of Death
Month MARCH Day 8 Year 2012
3. Time of Death
0942 AM

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Bayview Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

NH

5. Social Security Number

212-96-7333

6. Sex

M

F

7. Age (In yrs. last birthday)

92

Yrs.

If Under 1 Year

Months

Days

Hours

Min.

8. Date of Birth
(Month, Day, Year)

7/24/1919

9. Birthplace (State or Foreign Country)

Korea

10a. State

MD

10b. County

A.A.

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

Yes

No

10e. Street and Number

7900 Benesch Cir #841

10f. Zip-Code

21060

10g. Citizen of What Country?

USA

11. Marital Status

Never Married Married
 Widowed Divorced

12. Was Decedent Ever in U.S. Armed Forces?

Yes No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Yes No
Specify:

14. Race - American Indian, Black, White, etc.

Specify: Asian

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

College (1-4 or 5+)

Welder

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Sung Il Kim

18. Mother's Name (First, Middle, Maiden Surname)

T S Kim

19a. Informant's Name/Relationship (Type, Print)

Myung J Kim

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8712 Manahan Dr, Ellicott City, MD 21043

20a. Method of Disposition

Burial Cremation Removal from State
 Donation Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lakemont Memorial

Date

3/12/2012

20c. Location - City or Town, State

Davidsonville, MD

21. Signature of Funeral Service Licensee

► John Duck

22. Name and Address of Facility

Howell Funeral Home

10220 Guilford Rd, Jessup, MD 20794

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death

a. MULTI-SYSTEM ORGAN FAILURE

Due to (or as a consequence of):

b. HYPOVOLEMIC SHOCK

Due to (or as a consequence of):

c. 80% TOTAL BODY SURFACE AREA FULL THICKNESS BURN

Due to (or as a consequence of):

d.

JM/K CERTIFICATION APPROVED BY MEDICAL EXAMINER

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
 Yes No
 Unknown

23c. If yes, outcome of pregnancy
 Live birth Fetal death Ectopic pregnancy
 Pregnant at time of death Other (Specify)
 Unknown

23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

Yes No Probably Unknown

24a. Was an autopsy performed?
 Yes No

24b. Were autopsy findings available prior to completion of cause of death?
 Yes No

25. Was case referred to medical examiner?
 Yes No

Hospital: Inpatient ER/Outpatient DOA
Other: Nursing Home Residence Other (Specify)

26. Place of Death (Check only one)

27. Manner of Death

Natural
 Accident
 Suicide
 Homicide

5 Pending investigation
6 Could not be determined

28a. Date of Injury
(Month, Day, Year)

March 7, 2012

28b. Time of Injury

19:16 PM

28c. Injury at Work?
 Yes No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Home

28d. Describe how injury occurred

Self immolation

28f. Location (Street and Number or Rural Route Number, City or Town, State)

7900 Benesch Circle Glen Burnie MD 21060

29a. Certifier
(check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

► *John Klaaff, MD*

29c. License number

RES 000

29d. Date signed (Month, Day, Year)

MARCH, 8, 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JUSTIN KLAFF, MD

4940 Eastern Avenue, Baltimore, MD, 21224

31. Date filed (Month, Day, Year)

MAR 13 2012

32. Registered Nurse

Rebecca DeGraffenreid

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07722

1 For
State
Registrar

**Physician
/Medical
Examiner**

**Funeral
Director**

To Be Completed by Funeral Director

**Physician
/Medical
Examiner**

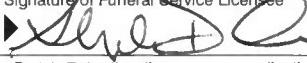
Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

1. Decedent's Name (First, Middle, Last) Ulysses Karitis							2. Date of Death Month March	Day 10	Year 2012	3. Time of Death 7:45 AM
4a. Facility Name (If not institution, give street and number) Johns Hopkins Bayview Medical Center							4b. City, Town, or Location of Death Baltimore			4c. County of Death N/A
5. Social Security Number 235-24-3097		6. Sex M	7. Age (In yrs. last birthday) 89	If Under 1 Year Months Yrs.	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 10/7/1922	9. Birthplace (State or Foreign Country) WEST VIRGINIA			
10a. State MD		10b. County N/A		10c. City, Town or Location BALTIMORE					10d. Inside City Limits X Yes	
10e. Street and Number 834 TOLNA STREET							10f. Zip-Code 21224	10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1942-1945			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ASSISTANT SUPERINTENDENT					16b. Kind of Business/Industry BETHLEHEM STEEL	
17. Father's Name (First, Middle, Last) THOMAS KARITIS							18. Mother's Name (First, Middle, Maiden Surname) MARY MIOKAFTIS			
19a. Informant's Name/Relationship (Type, Print) MARIE KARITIS-SMITH (DAUGHTER)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 36862 HERRING CT SELBYVILLE, DE 19975						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) GREEK ORTHODOX CEM.			Date 3/13/12	20c. Location - City or Town, State WOODLAWN, MD		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility CHARLES S. ZEILER AND SON, INC 6224 EASTERN AVE BALTIMORE, MD 21224						

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death One week					
<p>a. multiple organ system failure Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>															
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown 3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (specify) _____								23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Prostate cancer										23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred							
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)													
29a. Certifier (check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Carmelle T Norice, Resident Physician								29c. License number R55000		29d. Date signed (Month, Day, Year) March 10, 2012			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Carmelle T Norice, MD										4940 Eastern Avenue, Baltimore, MD, 21224					
31. Date filed (Month, Day, Year) MAR 13 2012		32. Registrar's Signature 													

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07723

1 - For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) The尔ma Madeline Kirk							2. Date of Death Month March 10 2012	3. Time of Death Year 9:30a M	
	4a. Facility Name (if not institution, give street and number) Bonds Forest			4b. City, Town, or Location of Death Finksburg			4c. County of Death Carroll			
Funeral Director	5. Social Security Number 215-22-9216		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 91 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) July 7 1920	9. Birthplace (State or Foreign Country) MD		
	10a. State MD		10b. County Carroll		10c. City, Town or Location Taneytown			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number 97 Crimson Avenue			10f. Zip Code 21787			10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates. 1920		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: white			14. Race - American Indian, Black, White, etc. Specify: white		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) homemaker			16b. Kind of Business/Industry domestic			
	17. Father's Name (First, Middle, Last) William Eitemiller				18. Mother's Name (First, Middle, Maiden Surname) Irene Lages					
	19a. Informant's Name/Relationship (Type, Print) Mr. Dennis Kirk (son)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4856 Cherry Tree Ln., Sykesville, MD 21784						
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Mt. Olive UMC Cem.			20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Olive UMC Cem.		Date 3-15-12	20c. Location - City or Town, State Randallstown, MD			
	21. Signature of Funeral Service Licensee Dawn Haught Herbst			22. Name and Address of Facility Haight Funeral Home & Chapel P.O. Box 195 Sykesville, MD 21784						
Physician/ Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Dementia								Approximate Interval Between Onset and Death years	
	<p>a. Due to (or as a consequence of): Dementia</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. _____</p>									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year		
Medical Certificate: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Resident living							
	27. Manner of Death Natural <input type="checkbox"/> Accident <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number He055845							
	29b. Signature and title of certifier Brewster, D.O.		29d. Date signed (Month, Day, Year) 3/12/2012							
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KEVIN BREWSTER, D.O.		31. Date filed (Month, Day, Year) MAR 13 2012							
State Registrar	32. Registrar's Signature S. Brewster									

Baltimore, Maryland 21215-0036

Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#29d, per PHYS, G925, 3/21/2012, WS

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07726

1 - For State Registrar

Physician/
Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/
Medical
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Division of Vital Records, P.O. Box 68760

State
Registrar

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death 2:35P M
Charles Richard Maynard, Sr.		03	08	2012		
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death				4c. County of Death
Watts Group Home Assisted Living		Severn				Anne Arundel
5. Social Security Number 219-12-3136 Usual Residence of Decedent		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (in yrs. last birthday) 87 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 03/31/1924	9. Birthplace (State or Foreign Country) Maryland
10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Linthicum Heights		
10e. Street and Number 6233 Medora Road				10f. Zip Code 21090		10g. Citizen of What Country? U.S.A.
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: White		14. Race - American Indian, Black, White, etc.
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 4		Manager		16b. Kind of Business/Industry Westinghouse
17. Father's Name (First, Middle, Last) Foster C. Maynard				18. Mother's Name (First, Middle, Maiden Surname) Ethel Edgar		
19a. Informant's Name/Relationship (Type, Print) Mrs. Joan Maynard / Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6233 Medora Road		19c. Date		20c. Location - City or Town, State Glen Burnie, MD
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) Selena Polinsky		20b. Place of Disposition (Name of cemetery, crematory or other place) Atlantic Crematory		03/10/2012		
21. Signature of Funeral Service Licensee MO1479 Selena Polinsky		22. Name and Address of Facility 1 2nd Avenue SW Glen Burnie, MD Singleton Funeral & Cremation Services, PA				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Stroke						Approximate Interval Between Onset and Death 9 months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. Due to (or as a consequence of):				
		b. Due to (or as a consequence of):				
		c. Due to (or as a consequence of):				
		d. _____				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Assisted Living				
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number 020094		29d. Date signed (Month, Day, Year) 03/09/2012		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Elliott Gorbaby MD, 1411 Madon Park Driv, Glen Burnie, Md, 21061						
31. Date filed (Month, Day, Year) MAR 13 2012		32. Registrar's Signature Anna J. Gates				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 U 1125

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

Medical Certificate: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death
Roland Lionel Martin		MARCH 12 2012		4:05 PM
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
BALTIMORE WASHINGTON MEDICAL CENTER		GLEN BURNIE		Anne Arundel
5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	8. Date of Birth (Month, Day, Year)
007-22-1106		<input checked="" type="checkbox"/> M <input type="checkbox"/> F	82 Yrs.	Dec 9, 1929
If Under 1 Year Months Days Hours Min.				9. Birthplace (State or Foreign Country)
				Maine
10a. State		10b. County	10c. City, Town or Location	
MD		Anne Arundel	Severn	
10e. Street and Number		10f. Zip Code		10g. Citizen of What Country?
1573 Loring Ct.		21144		USA
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No <input checked="" type="checkbox"/> Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Warrant Officer		16b. Kind of Business/Industry US Army
17. Father's Name (First, Middle, Last) Unk		18. Mother's Name (First, Middle, Maiden Surname) Janet Susan Zier		
19a. Informant's Name/Relationship (Type, Print) Janet Martin Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1573 Loring Ct., Severn, MD 21144		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Crownsville Veterans Cem		Date Mar 16, 2012
21. Sign _____ K. Gregory Fink		22. Name and Address of Facility Fink Funeral Home, P.A. 426 Crain Hwy S., Glen Burnie, MD 21061		20c. Location - City or Town, State Crownsville, MD
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Due to (or as a consequence of): - CANCER COLON SEPSIS		Approximate Interval Between Onset and Death
23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____		23d. Date of delivery Month Day Year		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred
				28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. Signature and title of certifier Berhane		29c. License number 00053703		29d. Date signed (Month, Day, Year) MARCH 12, 2012
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tsion Berhane, 301 Hospital Dr., Glen Burnie, MD 21061				
31. Date filed (Month, Day, Year) MAR 13 2012		32. Registrar's Signature James D. Farrel		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend #31 Per DMR G925 3/13/2012 Jh
State of Maryland / Department of Health and Mental Hygiene

1 - For
State
Registrar

Certificate of Death

Reg. No. 2012 07726

Physician/
Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last)		Janet S. McKegg		2. Date of Death Month March 9, Day Year 2012	3. Time of Death 4:00 A M		
4a. Facility Name (if not institution, give street and number) Elternhaus Assisted Living		4b. City, Town, or Location of Death Dayton		4c. County of Death Howard			
5. Social Security Number 219-68-9399		6. Sex 1 □ M 2 X F	7. Age (In yrs. last birthday) 58 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.		
				JAN 5, 1954	8. Date of Birth (Month, Day, Year)		
				9. Birthplace (State or Foreign Country) Maryland			
Usual Residence of Decedent							
10a. State MD	10b. County Howard	10c. City, Town or Location West Friendship			10d. Inside City Limits 1 □ Yes 2 X No		
10e. Street and Number 14026 Tall Ships Drive		10f. Zip Code 21794		10g. Citizen of What Country? USA			
11. Marital Status 1 □ Never Married 2 X Married	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 X No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 □ Yes 2 X No Specify:			14. Race - American Indian, Black, White, etc. White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 4 Wildlife Biologist			16b. Kind of Business Industry Maryland Department of Natural Resources		
17. Father's Name (First, Middle, Last) Homer Sponaugle			18. Mother's Name (First, Middle, Maiden Surname) Ennis Baker				
19a. Informant's Name/Relationship (Type, Print) Alfred H. McKegg, husband		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14026 Tall Ships Drive West Friendship, MD 21794					
20a. Method of Disposition 1 □ Burial 2 X Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc.		Date 03/10/12	20c. Location - City or Town, State Baltimore, MD		
21. Signature of Funeral Service Licensee George MacNabb <i>George E. MacNabb</i>		22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228					
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) FAILURE TO THRIVE						Approximate Interval Between Onset and Death	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last DEMENTIA ALZHEIMER'S DISEASE							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 X No 9 □ Unknown		23c. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. SEIZURE DISORDER DEPRESSION						23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 X No 3 □ Probably 4 □ Unknown	
25. Was case referred to medical examiner? 1 □ Yes 2 X No		26. Place of Death (Check only one) Hospital: 1 □ Inpatient 2 □ ER/Outpatient 3 □ DCA Other: 4 □ Nursing Home 5 □ Residence 6 X Other (Specify) ALF				24a. Was an autopsy performed? 1 □ Yes 2 X No 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 X No	
27. Manner of Death 1 X Natural 5 □ Pending Investigation 2 □ Accident 6 □ Could not be determined 3 □ Suicide 4 □ Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 □ Yes 2 □ No	28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 □ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 □ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier <i>Arvind Desai M.D.</i>		29c. License number D0063145		29d. Date signed (Month, Day, Year) 3/9/2012			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARVIND DESAI M.D. 405, DIGITAL DR LINTHICUM							
31. Date filed (Month, Day, Year) 3/9/12						32. Registrar's Signature <i>Laura J. Frantz</i>	

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

within 24 hours after death.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

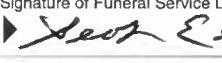
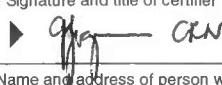
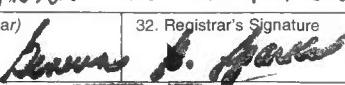
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07727

1 - For State Registrar		Decedent's Name (First, Middle, Last)						2. Date of Death		3. Time of Death	
		DAVID W. MOORE						Month Day Year		MARCH 10 2012 4:55 AM	
Physician /Medical Examiner		4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death			4c. County of Death			
		BAY RIDGE HEALTH CARE CENTER			ANNAPOLIS, MD			ANNE ARUNDEL			
Funeral Director		5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)		
		488-36-6374		1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	75 Yrs.			DEC 13, 1936	Missouri		
To Be Completed by Funeral Director		Usual Residence of Decedent						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
		10a. State	10b. County	10c. City, Town or Location				Annapolis			
		MD	Anne Arundel								
To Be Completed by Physician/Medical Examiner		10e. Street and Number			10f. Zip Code			10g. Citizen of What Country?			
		940 Bay Forest Court, # 322			21403			USA			
Physician /Medical Examiner		11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
				15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business/Industry		
				Elementary/Secondary (0-12)		College (1-4 or 5+) 4			Stock Broker		
To Be Completed by Physician/Medical Examiner		17. Father's Name (First, Middle, Last)				18. Mother's Name (First, Middle, Maiden Surname)					
		Arthur McRoe Moore				Blanche Dixon					
To Be Completed by Physician/Medical Examiner		19a. Informant's Name/Relationship (Type, Print)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)					
		Richard J. Moore, son				430 Duvall Lane Annapolis, Maryland 21403					
To Be Completed by Physician/Medical Examiner		20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date			20c. Location - City or Town, State		
		<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		Metro Crematory, Inc.		03/13/12			Baltimore, MD		
To Be Completed by Physician/Medical Examiner		21. Signature of Funeral Service Licensee		George MacNabb		22. Name and Address of Facility		Cremation Society of MD, Inc.			
						299 Frederick Road		Baltimore, MD 21228			
To Be Completed by Physician/Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death	
		Immediate Cause (Final disease or condition resulting in death)									
To Be Completed by Physician/Medical Examiner		a. <u>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</u> Due to (or as a consequence of):									
		b. <u>CONGESTIVE HEART FAILURE</u> Due to (or as a consequence of):									
To Be Completed by Physician/Medical Examiner		c. <u>PULMONARY HYPERTENSION</u> Due to (or as a consequence of):									
		d.									
To Be Completed by Physician/Medical Examiner		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) _____		23d. Date of delivery Month Day Year					
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
To Be Completed by Physician/Medical Examiner				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)		
To Be Completed by Physician/Medical Examiner		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
		29b. Signature and title of certifier 		29c. License number R188374			29d. Date signed (Month, Day, Year) MARCH 12, 2012				
To Be Completed by Physician/Medical Examiner		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		CAMILLE JOHNSON 900 VAN MAREN STREET, ANNAPOLIS MD 21403							
		31. Date filed (Month, Day, Year)		32. Registrar's Signature 							
To Be Completed by Physician/Medical Examiner		MAR 13 2012									

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07728

1 - For
State
Register

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last)					2. Date of Death Month <u>3</u> Day <u>9</u> Year <u>12</u>	3. Time of Death <u>11:15 AM</u>		
	James Joseph McNamee, III					4c. County of Death <u>N/A</u>			
Funeral Director	4a. Facility Name (if not institution, give street and number) <u>3811 Canterbury Road</u>			4b. City, Town, or Location of Death <u>Baltimore</u>			4c. County of Death <u>N/A</u>		
To Be Completed by Funeral Director	5. Social Security Number <u>213-32-0482</u>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <u>76</u> Yrs.	If Under 1 Year Months <u></u>	If Under 24 Hrs. Days <u></u>	8. Date of Birth (Month, Day, Year) <u>Apr. 29, 1935</u>	9. Birthplace (State or Foreign Country) <u>Maryland</u>		
	10a. State <u>Maryland</u>	10b. County <u>N/A</u>	10c. City, Town or Location <u>Baltimore</u>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <u>3811 Canterbury Road</u>			10f. Zip Code <u>21218</u>			10g. Citizen of What Country? <u>U.S.A.</u>		
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <u>White</u>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <u>5+ years</u>		16b. Kind of Business/Industry <u>Episcopal Priest</u>		Ministry		
	17. Father's Name (First, Middle, Last) <u>James Joseph McNamee, Jr.</u>			18. Mother's Name (First, Middle, Maiden Surname) <u>Dorothy Harden</u>					
	19a. Informant's Name/Relationship (Type, Print) <u>John W. Payne, M.D. (Per. Rep.)</u>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>4100 N. Charles St. Baltimore, Maryland 21218</u>					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <u>Green Mount Crematory</u>		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Green Mount Crematory</u>		Date <u>3-13-12</u>	20c. Location - City or Town, State <u>Baltimore, Maryland</u>			
	21. Signature of Funeral Service Licensee <u>J. Joseph Ferraro</u>			22. Name and Address of Facility <u>Mitchell-Wiedefeld Funeral Home, Inc.</u> <u>6500 York Road Baltimore, Maryland 21212</u>					
Physician/ Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <u>Necropsy of larynx</u>							Approximate Interval Between Onset and Death	
	a. Due to (or as a consequence of): <u>Necropsy of larynx</u>								
	b. Due to (or as a consequence of):								
	c. Due to (or as a consequence of):								
	d. _____								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____		23f. Date of delivery Month Day Year				
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <u>M0064267</u>				29d. Date signed (Month, Day, Year) <u>3-9-12</u>		
	29b. Signature and title of certifier <u>Karen Coors-Horan</u>								
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Dr. Karen Coors-Horan 827 Linden Av. Balt MD 21201</u>								
	31. Date filed (Month, Day, Year) <u>MAR 13 2012</u>		32. Registrar's Signature <u>James J. Ferraro</u>						

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

James McNamee 3/9 11:15am

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07729

**1 - For
State
Registrar**

**Physician/
Medical
Examiner**

**Funeral
Director**

To Be Completed by Funeral Director

Morgan Michael F.
Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician/
Medical
Examiner**

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07729

**1 - For
State
Registrar**

**Physician/
Medical
Examiner**

**Funeral
Director**

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) Michael Foley Morgan			2. Date of Death Month 3 Day 9 Year 2012	3. Time of Death 809A M
4a. Facility Name (if not institution, give street and number) FRANKLIN Square Hospital			4b. City, Town, or Location of Death Rosedale	
4c. County of Death Baltimore				
5. Social Security Number 214-58-8232		6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 58 Yrs.	8. Date of Birth (Month, Day, Year) 6-5-1953
9. Usual Residence of Decedent MD		10. City, Town or Location N/A		10d. Inside City Limits 1 Yes 2 No
10e. Street and Number 8745 Jarwood Rd.			10f. Zip Code 21237	
10g. Citizen of What Country? USA				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: Black
14. Race - American Indian, Black, White, etc. Specify: Black				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer		16b. Kind of Business/Industry Warehouse
17. Father's Name (First, Middle, Last) Sherman W. Morgan			18. Mother's Name (First, Middle, Maiden Surname) Rosia Lee Grings	
19a. Informant's Name/Relationship (Type, Print) Erika Morgan - Ex-Wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15 Baltistan Ct. Baltimore County, MD 21232	
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) Burial		20b. Place of Disposition (Name of cemetery, crematory, or other place) Greenmount Cemetery		Date 3/12/12
20c. Location - City or Town, State Baltimore, MD				
21. Signature of Funeral Service Licensee Bruce M. Hansen		22. Name and Address of facility March 7/11 - East 1101 E. Baltimore, MD 21202		
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Fatal Arrhythmia Due to (or as a consequence of): Renal Failure Due to (or as a consequence of): Electrolyte Imbalance Due to (or as a consequence of):				
Approximate Interval Between Onset and Death hrs				
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
23b. If female: Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown				
23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown				
23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				
28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. Signature and title of certifier DR Jonathan Hansen MD		29c. License number D0061662		29d. Date signed (Month, Day, Year) 03/09/2012
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR Jonathan Hansen 9000 FRANKLIN Square DR Balt MD 21237				
31. Date filed (Month, Day, Year) MAR 13 2012		32. Registrar's Signature James J. Hansen		

**State
Registrar**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07730

1 - For
State
RegistrarPhysician/
Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

For
State
Registrar

1. Decedent's Name (First, Middle, Last)

Douglas S. Mays

2. Date of Death

Month

03

Day

08

Year

2012

3. Time of Death

4:10 AM

4a. Facility Name (if not institution, give street and number)

Union Memorial Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

216-48-9475

Usual Residence of Decedent

6. Sex

1 M 2 F

7. Age (In yrs. last birthday)

64

Yrs.

If Under 1 Year

Months Days Hours Min.

8. Date of Birth

(Month, Day, Year)

9/12/47

9. Birthplace (State or Foreign Country)

Maryland

10a. State

Md.

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

4008 Hillcrest Ave.

10f. Zip Code

21225

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 Yes 2 No Specify:14. Race - American Indian, Black, White, etc.
Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) College (1-4 or 5+)

+5

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Artist

16b. Kind of Business/Industry

Art

17. Father's Name (First, Middle, Last)

Benjamin

Mays

18. Mother's Name (First, Middle, Maiden Surname)

Anita

Stewart

19a. Informant's Name/Relationship (Type, Print)

Mary Elizabeth Mays (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4008 Hillcrest Ave. Baltimore, Md. 21225

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory Inc.

Date

3/9/12

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

► [Signature]

22. Name and Address of Facility

Stallings Funeral Home PA

3111 Mountain Rd. Pasadena, Md. 21122

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death

4 days

Myocardial infarction

Due to (or as a consequence of):

Stroke

Due to (or as a consequence of):

Disease

Due to (or as a consequence of):

Disease

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No
9 Unknown

23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify)
9 Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

26. Place of Death (Check only one)

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other:1 Inpatient 2 ER/Outpatient 3 DOA Other:4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 5 Pending Investigation
2 Accident 6 Could not be determined
3 Suicide
4 Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work?

1 Yes 2 No

28d. Describe how injury occurred

M

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

► [Signature]

29c. License number

AT 243 8946-D7

29d. Date signed (Month, Day, Year)

3/8/2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Aditya Jain, 201 E University Pkwy, Baltimore, MD 21218

31. Date filed (Month, Day, Year)

MAR 13 2012

32. Registrar's Signature

► [Signature]

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2012 07731

Reg. No.

1- For
State
RegistrarPhysician/
Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/
Medical
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death	
<i>Dennis Joseph Milito Sr.</i>		Month	Day	Year	Reg. No.
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death	
<i>Medstar HARBOR Hospital</i>		<i>Baltimore MD</i>		<i>N/A</i>	
5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.
<i>213-52-5433</i>		<input checked="" type="checkbox"/> M <input type="checkbox"/> F	<i>63</i> Yrs.	Months	Days
8. Usual Residence of Decedent		9. Date of Birth (Month, Day, Year)	10. Birthplace (State or Foreign Country)		
<i>Maryland Baltimore</i>		<i>June 16 1948</i>	<i>MD</i>		
10a. State		10b. County		10d. Inside City Limits	
<i>Maryland</i>		<i>Baltimore</i>		<i>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</i>	
10e. Street and Number		10f. Zip Code		10g. Citizen of What Country?	
<i>709 Fernvalley Circle, Apt. 5</i>		<i>21229</i>		<i>USA</i>	
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	
<i>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</i>		<i>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.</i>		<i>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:</i>	
14. Race - American Indian, Black, White, etc.		15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	
<i>White</i>		<i>Elementary/Secondary (0-12) 12</i>		<i>Electrician</i>	
16b. Kind of Business/Industry					
				<i>Union Local 24</i>	
17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)			
<i>Alphonse R. Milito</i>		<i>Amelia M. Carricato</i>			
19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
<i>Virginia F. Milito (spouse)</i>		<i>4921 Brookwood Road, Baltimore, MD 21225</i>			
20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date	20c. Location - City or Town, State
<i>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</i>		<i>Metro Crematory Inc.</i>		<i>March 13 2012</i>	<i>Baltimore, Maryland</i>
21. Signature of Funeral Service Licensee		22. Name and Address of Facility		23. Part I. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	
<i>Marshall Stallings</i>		<i>Stallings Funeral Home, P.A.</i>		<i>not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death</i>	
				<i>Metastatic right lung cancer 2 weeks</i>	
23a. Part II. Enter sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23b. Due to (or as a consequence of):			
		<i>a. Metastatic right lung cancer</i>			
		23c. Due to (or as a consequence of):			
		<i>b. Hypertension</i>			
		23d. Due to (or as a consequence of):			
		<i>c. Hypertension</i>			
		23e. Did tobacco use contribute to the cause of death?			
		<i>d. Hypertension</i>		<i>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</i>	
23b. Was decedent pregnant in the past 12 months?		23c. If yes, outcome of pregnancy		23d. Date of delivery	
<i>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown</i>		<i>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown</i>		Month Day Year	
25. Was case referred to medical examiner?		26. Place of Death (Check only one)		23e. Did tobacco use contribute to the cause of death?	
<i>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</i>		<i>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA</i>		<i>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</i>	
27. Manner of Death		28a. Date of injury (Month, Day, Year)		28b. Time of injury	
<i>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</i>		<i>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined</i>		<i>M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</i>	
28c. Injury at work?		28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
<i>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</i>				<i>28f. Location (Street and Number or Rural Route Number, City or Town, State)</i>	
29a. Certifier		29c. License number		29d. Date signed (Month, Day, Year)	
<i>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</i>		<i>RES-001</i>		<i>03/11/2012</i>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)					
<i>Indriana Bisar Indriana Bisarimo 3001 S. Hanover STREET Baltimore MD 21225</i>					
31. Date filed (Month, Day, Year)		32. Registrar's Signature			
<i>MAR 13 2012</i>		<i>Indriana Bisar</i>			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#18perFH, G925, 3/13/2012 WS

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07732

1 - For
State
Registrar

Physician/
Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Robert Mungin 3-9-12
Baltimore, Maryland 21215-0036
Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Robert Mungin
Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10 fm
State
Registrar

Medical Certificate: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Robert Elijah Mungin				2. Date of Death Month March Day 9 Year 2012	3. Time of Death 4:37PM
4a. Facility Name (if not institution, give street and number) 9613 Button Buck Circle		4b. City, Town, or Location of Death Randallstown		4c. County of Death Baltimore	
5. Social Security Number 219-26-4840	6. Sex M	7. Age (In yrs. last birthday) 73 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) 09/26/1928
9. Usual Residence of Decedent Baltimore				9. Birthplace (State or Foreign Country) WV	
10a. State MD	10b. County Baltimore	10c. City, Town or Location Randallstown			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number 9613 Button Buck Circle			10f. Zip Code 21133		10g. Citizen of What Country? USA
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates. 12th grade		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerk		16b. Kind of Business/Industry US Post Office	
17. Father's Name (First, Middle, Last) Elijah Mungin			18. Mother's Name (First, Middle, Maiden Surname) Esther Mungin		
19a. Informant's Name/Relationship (Type, Print) Esther Mungin		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9613 Button Buck Circle Randallstown MD 21133			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Garrison Forest VA		20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest VA		Date 03/16/2012	20c. Location - City or Town, State Owings Mills, MD
21. Signature of Funeral Service Licensee Vaughn C. Greene		22. Name and Address of Facility Vaughn C. Greene Funeral Services 8728 Liberty Road Randallstown MD 21133			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CEREBRO VASCULAR ACCIDENT					
Approximate Interval Between Onset and Death 15 minutes					
a. Due to (or as a consequence of): ATHEROSCLEROSIS					
b. Due to (or as a consequence of): HYPERTENSION					
c. Due to (or as a consequence of): DIABETES MELLITUS TYPE 2					
d.					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION					
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year) 1/12/2012	28b. Time of injury M 1	28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 1	28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) At home		28f. Location (Street and Number or Rural Route Number, City or Town, State) Baltimore MD 21228			
29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Ramana Gopalan MD			
29c. License number DS1228		29d. Date signed (Month, Day, Year) 3/12/2012			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAMANA GOPALAN MD 2E ROLLING CROSS ROADS BALTIMORE MD 21228					
31. Date filed (Month, Day, Year) MAR 13 2012		32. Registrar's Signature James A. Park			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend item 30 per dvr g925 3-13-12 vt

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07733

1- For
State
Registrar

Physician/
Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

(X)

Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death	
<i>Mildred, Matthews</i>		3	11	12	1035	AM	
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death				4c. County of Death	
<i>Riverview Nursing Center</i>		<i>Essex</i>				<i>Baltimore</i>	
5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>April 16, 1923</i>	9. Birthplace (State or Foreign Country) <i>MD</i>
10a. State <i>MD</i>		10b. County <i>Baltimore</i>		10c. City, Town or Location <i>Essex</i>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number <i>623 Dunwich Way</i>				10f. Zip Code <i>21221</i>			10g. Citizen of What Country? <i>USA</i>
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <i>White</i>			14. Race - American Indian, Black, White, etc. Specify: <i>White</i>
15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Secondary (0-12) 9th</i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Can Press Operator</i>			16b. Kind of Business/Industry <i>American Can Co.</i>
17. Father's Name (First, Middle, Last) <i>Charles McCord</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Minnie Weitzel</i>			
19a. Informant's Name/Relationship (Type, Print) <i>Bernard Matthews /son</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1200 Roxboro Road Rosedale MD 21237</i>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>► Robert Teg Connely I</i>				20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Gardens of Faith</i>		Date <i>3/16/12</i>	20c. Location - City or Town, State <i>Rossville MD</i>
21. Signature of Funeral Service Licensee <i>Robert Teg Connely I</i>				22. Name and Address of Facility <i>300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221</i>			
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or near failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Advanced Dementia</i>							
Approximate Interval Between Onset and Death							
b. Due to (or as a consequence of): <i>{</i>							
c. Due to (or as a consequence of): <i></i>							
d. Due to (or as a consequence of): <i></i>							
IF FEMALE:		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29b. Signature and title of certifier <i>► Natasha Loving</i>		29c. License number <i>11666662</i>				29d. Date signed (Month, Day, Year) <i>3-12-12</i>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Natasha Loving Riverview Nursing Center</i>							
31. Date filed (Month, Day, Year) <i>MAR 13 2012</i>		32. Filer's Signature <i>Susan S. Parker</i>					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07734

1 - For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) James Patrick McCusker						2. Date of Death Month March Day 10 Year 2012	3. Time of Death 10:57a M
	4a. Facility Name (if not institution, give street and number) Carroll Hospital Center			4b. City, Town, or Location of Death Westminster			4c. County of Death Carroll	
Funeral Director	5. Social Security Number 218-62-0681	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 59 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month Day Year) 9/15/1952	9. Birthplace (State or Foreign Country) MD	
To Be Completed by Funeral Director	10a. State MD 10b. County Carroll			10c. City, Town or Location Hampstead			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 928 South Main Street			10f. Zip Code 21074			10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) sales telemarketer			16b. Kind of Business/Industry sales	
	17. Father's Name (First, Middle, Last) Hugh A. McCusker				18. Mother's Name (First, Middle, Maiden Surname) Hilda Berryman			
	19a. Informant's Name/Relationship (Type, Print) Linda Holler, sister			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1592 Wall Drive, Pasadena, MD 21122				
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) <i>Carroll Cremation</i>			20b. Place of Disposition (Name of cemetery, crematory or other place)		Date 3/14/12	20c. Location - City or Town, State Hampstead, MD	
Physician/ Medical Examiner	21. Signature of Funeral Service Licensee <i>Wanda L. Lemmer</i>			22. Name and Address of Facility Eline Funeral Home 934 S. Main Street, Hampstead, MD 21074				
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Chronic Obstructive Pulmonary Disease Approximate Interval Between Onset and Death Years							
	a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							
	23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
	26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide							
	28a. Date of injury (Month, Day, Year) 28b. Time of injury M 28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred							
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier <i>Willow Kuo</i>							
	29c. License number D0058137							
	29d. Date signed (Month, Day, Year) 3/12/12							
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Willow Kuo 295 Stone Ave St 307 Westminster MD 21157							
	31. Date filed (Month, Day, Year) MAR 13 2012							
	32. Physician's Signature <i>James Patrick McCusker</i>							

Baltimore, Maryland 21215-0036

Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Medical Certificate: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07735

1- For
State
RegistrarPhysician/
Medical
Examiner

1. Decedent's Name (First, Middle, Last) Eugene R. Morrison							2. Date of Death Month March Day 8 , Year 2012	3. Time of Death 1:00 A M
4a. Facility Name (if not institution, give street and number) 3120 Coon Club Road				4b. City, Town, or Location of Death Hampstead			4c. County of Death Carroll County	
5. Social Security Number 169-26-4525		6. Sex 1 X M	7. Age (in yrs. last birthday) 79 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) Aug. 23, 1932	9. Birthplace (State or Foreign Country) West Virginia	
10a. State Maryland		10b. County Carroll County		10c. City, Town or Location Hampstead				10d. Inside City Limits 1 □ Yes 2 X No
10e. Street and Number 3120 Coon Club Road				10f. Zip Code 21074			10g. Citizen of What Country? United States	
11. Marital Status 1 □ Never Married 2 X Married 3 □ Widowed 4 □ Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 X No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 X No Specify:			14. Race - American Indian, Black, White, etc. Specify: white
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) groundskeeper			16b. Kind of Business/Industry lawn maintenance	
17. Father's Name (First, Middle, Last) Lee Morrison					18. Mother's Name (First, Middle, Maiden Surname) Mary Savage			
19a. Informant's Name/Relationship (Type, Print) Fonda Abbott - daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 198 Adeline Drive Westminster, Maryland 21157				
20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Hampstead Cemetery			Date March 12, 2012	20c. Location - City or Town, State Hampstead, Maryland	
21. Signature of Funeral Service Licensee  M01072			22. Name and Address of Facility Eline Funeral Home 934 South Main Street Hampstead, Maryland 21074					

Physician/
Medical
Examiner

To Be Completed by Physician/Medical Examiner

A.J.

Medical Certificate: To Be Completed by Physician/Medical Examiner

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death					
<p>a. <u>Coronary Artery Disease + COPD</u> Due to (or as a consequence of):</p> <p>b. <u>Diabetes Mellitus + Hypertension + Hyperlipidemia</u> Due to (or as a consequence of):</p> <p>c. <u>Metabolic Syndrome (obesity)</u> Due to (or as a consequence of):</p> <p>d. _____</p>							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		23c. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) _____ 9 □ Unknown				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Anemia Depression							23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 X No 3 □ Probably 4 □ Unknown
25. Was case referred to medical examiner? 1 □ Yes 2 X No		26. Place of Death (Check only one) Hospital: 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 □ Nursing Home 5 X Residence 6 □ Other (Specify)					
27. Manner of Death 1 X Natural 5 □ Pending Investigation 2 □ Accident 6 □ Could not be determined 3 □ Suicide 4 □ Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? 1 □ Yes 2 □ No	28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 □ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier 		29c. License number D0067957			29d. Date signed (Month, Day, Year) 03.09.2012		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Victoria Wilson 2970 Deede Road Ste 4 Finksburg MD 21042							
31. Date filed (Month, Day, Year) MAR 13 2012		32. Registrar's Signature 					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

To Be Completed by Funeral Director

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07736

1- For State Registrar**Physician/Medical Examiner**

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death 2230 hrs
Suzanne Mary Mercier	March 6, 2012	

Funeral Director

4a. Facility Name (if not institution, give street and number) Route 26 at Route 32	4b. City, Town, or Location of Death Eldersberg	4c. County of Death Carroll			
5. Social Security Number 215-54-0194	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 64 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (MM/DD/YYYY) Jan. 19 1948	9. Birthplace (State or Foreign Country) MD

Usual Residence of Decedent		10a. State MD	10b. County Carroll	10c. City, Town or Location Sykesville	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
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10e. Street and Number 609 Tanglewood Drive	10f. Zip Code 21784	10g. Citizen of What Country? USA
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11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify:	14. Race - American Indian, Black, White, etc. Specify: white
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15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 2	16b. Kind of Business/Industry retail salesperson
--	---	--

17. Father's Name (First, Middle, Last) Gerald Derenberger	18. Mother's Name (First, Middle, Maiden Surname) Margaret Lardusky
---	--

19a. Informant's Name/Relationship (Type, Print) Mr. Robert Mercier (husband)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 609 Tanglewood Dr., Sykesville, MD 21784
--	---

20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State	20b. Place of Disposition (Name of cemetery, crematory or other place) All County Cremation	Date 3-9-12	20c. Location - City or Town, State Sykesville, MD
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21. Signature of Funeral Service Licensee <i>Dawn Stauth-Turkert</i>	22. Name and Address of Facility Haight Funeral Home & Chapel P.O. Box 195 Sykesville, MD 21784
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Baltimore, MD 21215-0036

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)		a. Multiple Injuries Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. Due to (or as a consequence of):
		c. Due to (or as a consequence of):
		d.
<input type="checkbox"/> UNPENDED	<input type="checkbox"/> AMENDED	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1 <input type="checkbox"/> Live birth 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown	2 <input type="checkbox"/> Fetal death 5 <input type="checkbox"/> Other (Specify) _____	3 <input type="checkbox"/> Ectopic pregnancy	23d. Date of delivery Month Day Year
---	---	--	--	---

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
--	--

25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other Scene
---	---

27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day, Year) Mar 6, 2012	28b. Time of Injury 2223 hrs	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	28d. Describe how injury occurred Subject driver of SUV that ran red light and struck by 2 vehicles
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5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Major Road / Highway	28f. Location (Street and Number or Rural Route Number, City or Town, State) Route 26 at Route 32, Eldersberg, MD
--	--	--

29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29b. Signature and title of certifier <i>Victor Weedn</i>	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) March 7, 2012
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30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223
--

31. Date filed (Month, Day, Year) MAR 13 2012	32. Registrar's Signature <i>Suzanne J. Mercier</i>
--	--

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07737

1- For
State
Registrar

Physician/
Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Physician/
Medical
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

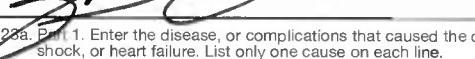
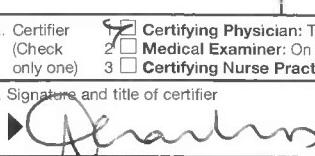
State
Registrar

1. Decedent's Name (First, Middle, Last)		MUSSIENKO		2. Date of Death	Month	Day	Year	3. Time of Death	
BORIS				MARCH		10	2012	03:56 AM	
4a. Facility Name (if not institution, give street and number)		THE SORBS HOPKINS HOSPITAL		4b. City, Town, or Location of Death		4c. County of Death			
THE SORBS HOPKINS HOSPITAL				BALTIMORE CITY					
5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		9. Birthplace (State or Foreign Country)	
065-34-9183		1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	67	Months	Days	Hours	Min.	OCT 03, 1944 Austria	
Usual Residence of Decedent		10a. State MD		10b. County Prince Georges		10c. City, Town or Location Upper Marlboro		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 6101 Whittemore Ct.		10f. Zip Code 20772		10g. Citizen of What Country? United States					
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: Vietnam		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+		16b. Kind of Business/Industry Appraiser		Personal Property			
17. Father's Name (First, Middle, Last) Jefim Mussienko		18. Mother's Name (First, Middle, Maiden Surname) Elena Heinrich							
19a. Informant's Name/Relationship (Type, Print) Louise Helen Mussienko /Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6101 Whittemore Ct. Upper Marlboro, MD 20772							
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory		Date Mar 13, 2012	20c. Location - City or Town, State Beltsville, Maryland				
21. Signature of Funeral Service Licensee Lynda Sue Miller Mo1443		22. Name of Funeral Alternative 8717 Green Pastures Drive Towson Maryland 21286							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Due to (or as a consequence of): CORONARY ARTERY DISEASE				Approximate Interval Between Onset and Death			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. Due to (or as a consequence of):							
		b. Due to (or as a consequence of):							
		c. Due to (or as a consequence of):							
		d. Due to (or as a consequence of):							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery		Month	Day	Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death?		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		26. Place of Death (Check only one)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier CLAUDIO BEATY		29c. License number RES 606		29d. Date signed (Month, Day, Year) MARCH 10 2012			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		31. Date filed (Month, Day, Year) MAR 13 2012		32. Registrar's Signature Seneca S. Parker					

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

For State Registrar		State of Maryland / Department of Health and Mental Hygiene		Certificate of Death		Reg. No. 2012 07738	
1. Decedent's Name (First, Middle, Last) Eddie R. Massey, Sr.				2. Date of Death March 7, 2012		3. Time of Death 8 00 PM	
4a. Facility Name (if not institution, give street and number) Gilchrist Hospice				4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore	
5. Social Security Number 212-34-0140	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 73 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month Day Year) April 28, 1938	9. Birthplace (State or Foreign Country) MD	
10a. State MD	10b. County Baltimore	10c. City, Town or Location Baltimore				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 3118 BentLou Jsames Pl.			10f. Zip Code 21207			10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 2 Yrs.		16b. Kind of Business/Industry Proctor and Gamble Corp.			
17. Father's Name (First, Middle, Last) Henry James Massey				18. Mother's Name (First, Middle, Maiden Surname) Margie Little			
19a. Informant's Name/Relationship (Type, Print) Annie Massey/Wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3118 Bent Lou James Pl. Balto., MD 21207				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Druid Ridge Cem		Date 3/12/12	20c. Location - City or Town, State Pikesville, MD		
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Beverly D. Cromartie F/S 2700 Edmondson Ave. Balto., MD 21223					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Alzheimer dementia							
Approximate Interval Between Onset and Death years							
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
<p>a. Due to (or as a consequence of): Alzheimer dementia</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. .</p>							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
<p>24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<p>26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice</p>					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
						28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
						28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier 			29c. License number D58303			29d. Date signed (Month, Day, Year) March 8 2012	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ashton J Charles ms 6701 N. Charles St Towson MD							
31. Date filed (Month, Day, Year) MAR 13 2012		32. Registrar's Signature 					

Baltimore, Maryland 21215-0036

Attending Physician: The law requires that the death certificate be executed after death.

To the Hospital or Attendi-
within 24 hours after death.

✓

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

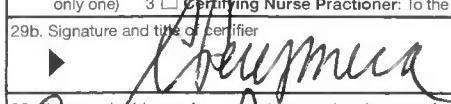
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07739

1 - For
State
Registrar

**Physician/
Medical
Examiner**

Funeral Director		1. Decedent's Name (First, Middle, Last) Lawrence Edward Noble					2. Date of Death Month 03 /Day 09 /Year 2012	3. Time of Death 4:56 A M
		4a. Facility Name (if not institution, give street and number) 634 S. Newkirk St.		4b. City, Town, or Location of Death Baltimore			4c. County of Death	
		5. Social Security Number 266-54-6924	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 74 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) 03/21/1938	9. Birthplace (State or Foreign Country) NJ
		Usual Residence of Decedent 10a. State MD					10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
		10b. County			10c. City, Town or Location Baltimore			
		10e. Street and Number 359 Elrino St.			10f. Zip Code 21224		10g. Citizen of What Country? USA	
		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc.	
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Owner			16b. Kind of Business Industry Sales	
		17. Father's Name (First, Middle, Last) Edward Noble			18. Mother's Name (First, Middle, Maiden Surname) Mary Bonvicini			
		19a. Informant's Name/Relationship (Type, Print) Joanna R. Boduroglu- Friend		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 634 S. Newkirk St. Baltimore, MD 21224				
		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Atlantic Crematory		Date 3/10/2012	20c. Location - City or Town, State Glen Burnie, MD	
		21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Charles S. Zeiler and Son Inc. 6224 Eastern Ave. Baltimore, MD 21224				
Physician/ Medical Examiner		<p>23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.</p> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. Due to (or as a consequence of): Metastatic Colon Cancer</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p> <p>Approximate Interval Between Onset and Death</p>						
		23b. If FEMALE: Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year	
		<p>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</p> <p>23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</p> <p>24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</p> <p>24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</p>						
		25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Friend's		
		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)	
		<p>29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</p> <p>29b. Signature and title of certifier </p> <p>29c. License number D10613</p> <p>29d. Date signed (Month, Day, Year) 3-9-2012</p>						
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rafael Perez-Mera, M.D.		32. Registrar's Signature 				
		31. Date filed (Month, Day, Year) MAR 13 2012		32. Registrar's Signature 				

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

10 v

**State
Registrar**

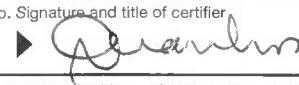
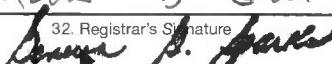
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07740

1- For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) JANSET NAHUM					2. Date of Death Month MARCH Day 09 Year 2012	3. Time of Death 02:12A M
	4a. Facility Name (if not institution, give street and number) GILCHRIST HOSPICE CARE					4b. City, Town, or Location of Death TOWSON	4c. County of Death BALTIMORE
Funeral Director	5. Social Security Number 216-72-7643	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 78 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month Day Year) 03/25/1933	9. Birthplace (State or Foreign Country) TURKEY
To Be Completed by Funeral Director	10a. State MD	10b. County BALTIMORE	10c. City, Town or Location BALTIMORE	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	10e. Street and Number 7921 LONG MEADOW ROAD			10f. Zip Code 21208		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 2 REGISTERED NURSE		16b. Kind of Business/Industry NURSING		
	17. Father's Name (First, Middle, Last) CAVIT ARANLAR			18. Mother's Name (First, Middle, Maiden Surname) CEVAHIR UNKNOWN			
	19a. Informant's Name/Relationship (Type, Print) ALBERT NAHUM/HUSBAND			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7921 LONG MEADOW ROAD, BALTIMORE, MD 21208			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) DRUID RIDGE CEMETERY	Date 03/12/2012	20c. Location - City or Town, State PIKESVILLE, MD	
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208			
Physician/ Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Non small cell lung cancer						
	Approximate Interval Between Onset and Death months						
	23b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown						
	23d. Date of delivery Month Day Year						
	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown						
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						
	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospital						
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide						
	28a. Date of injury (Month, Day, Year) 28b. Time of injury M 28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred						
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						
	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
	29b. Signature and title of certifier 						
	29c. License number D58303						
	29d. Date signed (Month, Day, Year) March 9 2012						
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANNE J CHARLES MD G701 N. Charles St Towson MD						
	31. Date filed (Month, Day, Year) MAR 13 2012						
	32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Reg. No. 2012 07741

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) Joseph Neisser						2. Date of Death Month March Day 10 Year 2012	3. Time of Death 8:55p M	
Funeral Director		4a. Facility Name (if not institution, give street and number) 517 Dorsey Avenue			4b. City, Town, or Location of Death Essex			4c. County of Death Baltimore		
To Be Completed by Funeral Director		5. Social Security Number 214-36-9163		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 71 Yrs.		If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) May 13, 1940	9. Birthplace (State or Foreign Country) MD
		Usual Residence of Decedent 10a. State MD 10b. County Baltimore		10c. City, Town or Location Essex						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
To Be Completed by Funeral Director		10e. Street and Number 517 Dorsey Avenue			10f. Zip Code 21221			10g. Citizen of What Country? USA		
		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates. 9th			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. Specify: White
To Be Completed by Funeral Director		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Custodian			16b. Kind of Business/Industry Balto. County		
		17. Father's Name (First, Middle, Last) Arthur P. Neisser			18. Mother's Name (First, Middle, Maiden Surname) Alice V. Spencer					
To Be Completed by Physician/Medical Examiner		19a. Informant's Name/Relationship (Type, Print) Gene C. Neisser /wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 517 Dorsey Avenue Baltimore MD 21221					
		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Holly Hill Cemetery			Date 3/14/12	20c. Location - City or Town, State Baltimore MD	
To Be Completed by Physician/Medical Examiner		21. Signature of Funeral Service Licensee John T. Connally Jr.			22. Name and Address of Facility 300 Mace Ave. Balto. MD Connally Funeral Home of Essex 21221					
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)			23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. End stage Emphysema			Approximate Interval Between Onset and Death		
To Be Completed by Physician/Medical Examiner		23c. If female: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year					
		23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
To Be Completed by Physician/Medical Examiner		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
To Be Completed by Physician/Medical Examiner		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
To Be Completed by Physician/Medical Examiner		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)					
To Be Completed by Physician/Medical Examiner		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier Sheldon Milner MD			29c. License number 018398	29d. Date signed (Month, Day, Year) 3/10/12	
To Be Completed by Physician/Medical Examiner		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			31. Date filed (Month, Day, Year) MAR 13 2012			32. Registrar's Signature Sheldon Milner		

Division of Vital Records, P.O. Box 68760

To The Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To The Funeral Director: After this certificate has been signed by the attending physician and

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

BUML 13 Rev. 06.2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07742

**1 - For
State
Registrar**

**Physician/
Medical
Examiner**

**Funeral
Director**

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate To Be Completed by Physician/Medical Examiner

**State
Registrar**

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month March Day 8, Year 2012			3. Time of Death 5:50 P M	
Lewis A. Ottenritter							
4a. Facility Name (if not institution, give street and number) Friends Nursing Home			4b. City, Town, or Location of Death Sandy Spring			4c. County of Death Montgomery	
5. Social Security Number 218-32-0860		6. Sex 1 X M 2 F	7. Age (in yrs. last birthday) 76 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) SEP 5, 1935	9. Birthplace (State or Foreign Country) Maryland
Usual Residence of Decedent 10a. State MD			10b. County Howard			10c. City, Town or Location Glenwood	
10e. Street and Number 2816 Sagewood Drive			10f. Zip Code 21738			10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates. 1961-63		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) 5+			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Physician			16b. Kind of Business Industry Health Care	
17. Father's Name (First, Middle, Last) Phillip			18. Mother's Name (First, Middle, Maiden Surname) Ottenritter			Lillian Redmer	
19a. Informant's Name/Relationship (Type, Print) Janet J. Ottenritter, wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2816 Sagewood Drive Glenwood, Maryland 21738				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) Metro Crematory, Inc.			20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc.			Date 03/10/12	20c. Location - City or Town, State Baltimore, MD
21. Signature of Funeral Service Licensee George MacNabb			22. Name and Address of Facility Cremation Society of MD, Inc.			22. Name and Address of Facility 299 Frederick Road Baltimore, MD 21228	
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)			23b. Due to (or as a consequence of): Alzheimer's Dementia			Approximate Interval Between Onset and Death	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			23c. Due to (or as a consequence of):				
23d. Due to (or as a consequence of):			23e. Due to (or as a consequence of):				
23f. Due to (or as a consequence of):			23g. Due to (or as a consequence of):				
23h. Due to (or as a consequence of):			23i. Due to (or as a consequence of):				
IF FEMALE:			23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year	
23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown			23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			23f. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			23g. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Homicide			28a. Date of injury (Month, Day, Year)			28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28d. Describe how injury occurred	
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29c. License number D39793			29d. Date signed (Month, Day, Year) March 9, 2012	
29b. Signature and title of certifier Christopher J. Mays, MD			29c. License number D39793			29d. Date signed (Month, Day, Year) March 9, 2012	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Christopher J. Mays, MD 18111 Ponico Philip Drive, Olney, MD 20832							
31. Date filed (Month, Day, Year) MAR 13 2012			32. Registrar's Signature Christopher J. Mays				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07 11 3

1- For State Registrar		1. Decedent's Name (First, Middle, Last) Josef Orlitzky						2. Date of Death Month Day Year March 7 2012		3. Time of Death 12:50A.M							
Physician /Medical Examiner		4a. Facility Name (If not institution, give street and number) Ivy Hall Geriatric Rehabilitation Center						4b. City, Town, or Location of Death Middle River		4c. County of Death Baltimore County							
Funeral Director		5. Social Security Number 072-40-2597		6. Sex 1X M 2□ F		7. Age (In yrs. last birthday) 85 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.							
To Be Completed by Funeral Director		8. Date of Birth (Month, Day, Year) Dec. 20, 1926						9. Birthplace (State or Foreign Country) Romania									
		Usual Residence of Decedent 10a. State Maryland						10b. County Baltimore County		10c. City, Town or Location Baldwin		10d. Inside City Limits 1□ Yes 2□ No					
		10e. Street and Number 2519 Greene Road						10f. Zip Code 21013		10g. Citizen of What Country? United States							
		11. Marital Status 1□ Never Married 2□ Married 3□ Widowed 4X Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1□ Yes 2X No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1□ Yes 2X No Specify:		14. Race - American Indian, Black, White, etc. Specify: White									
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12						16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Superintendent		16b. Kind of Business/Industry Property Manager							
		17. Father's Name (First, Middle, Last) Unknown						18. Mother's Name (First, Middle, Maiden Surname) Unknown									
		19a. Informant's Name/Relationship (Type, Print) Mr. Bert Orlitzky (Son)						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2519 Greene Road, Baldwin, Maryland 21013									
		20a. Method of Disposition 1□ Burial 2X Cremation 3□ Removal from State 4□ Donation 5□ Other (Specify) ▶ <i>Evans Funeral Chapel</i>			20b. Place of Disposition (Name of cemetery, crematory or other place) Evans Funeral Chapel			Date 03/07/2012		20c. Location - City or Town, State Forest Hill, Maryland							
		21. Signature of Funeral Service Licensee ▶ <i>James J. Lebow</i>						22. Name and Address of Facility Evans Funeral Chapel & Cremation Services-Bel Air 3 Newport Drive, Forest Hill, Maryland 21050									
Physician /Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death 1-2 hrs <i>Suspected Cardiac Arrhythmias.</i>									
		a. Due to (or as a consequence of): <i>Atherosclerotic coronary artery Disease unknown</i>															
		b. Due to (or as a consequence of):															
		c. Due to (or as a consequence of):															
		d. Due to (or as a consequence of):															
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1□ Yes 2□ No 9□ Unknown			23c. If yes, outcome pf pregnancy 1□ Live birth 2□ Fetal death 4□ Pregnant at time of death 9□ Unknown			3□ Ectopic pregnancy 5□ Other (specify)			23d. Date of delivery Month Day Year						
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Severe choc惊厥. Fan cytopic Hypothyroidism, B12 Deficiency.</i>						23e. Did tobacco use contribute to the cause of death? 1□ Yes 2□ No 3□ Probably 4□ Unknown									
								24a. Was an autopsy performed? 1□ Yes 2X No						24b. Were autopsy findings available prior to completion of cause of death? 1□ Yes 2□ No			
		25. Was case referred to medical examiner? 1□ Yes 2X No		26. Place of Death (Check only one) Hospital: 1□ Inpatient 2□ ER/Outpatient 3□ DOA Other: 4X Nursing Home 5□ Residence 6□ Other (Specify)													
		27. Manner of Death 1X Natural 5□ Pending investigation 2□ Accident 6□ Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1□ Yes 2□ No		28d. Describe how injury occurred							
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)									
		29a. Certifier (Check only one) 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						29c. License number D-38754						29d. Date signed (Month, Day, Year) 03-07-2012			
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MALIKA WASEEM. 709 EASTERN BLVD, M.D. 21221.															
State Registrar		31. Date filed (Month, Day, Year) MAR 13 2012			32. Registrar's Signature <i>Seamus J. Farrel</i>												

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07714

1 - For
State
Registrar

Physician/
Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit slip.

Medical Certificate: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death	
Wayne J. Osowski		March 08 2012		02:18 PM	
4a. Facility Name (if not institution, give street and number) Baltimore Washington Medical		4b. City, Town, or Location of Death Glen Burnie		4c. County of Death Anne Arundel	
5. Social Security Number 399-50-6801		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 62 Yrs.	
8. If Under 1 Year Months Days		9. If Under 24 Hrs. Hours Min.		10. Date of Birth (Month, Day, Year) March 19 1949	
11. Usual Residence of Decedent Maryland Anne Arundel		12. If Under 1 Year Months Days		13. If Under 24 Hrs. Hours Min.	
14. Social Security Number 399-50-6801		15. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		16. Age (In yrs. last birthday) 62 Yrs.	
17. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		18. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates.		19. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
20. Usual Residence of Decedent Maryland Anne Arundel		21. Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		22. Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sheet Metal Worker	
23. Father's Name (First, Middle, Last) Julian Osowski		24. Mother's Name (First, Middle, Maiden Surname) Sophie Waletzko		25. Race - American Indian, Black, White, etc. Specify: White	
26. Informant's Name/Relationship (Type, Print) Lori Osowski (spouse)		27. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 223 Pike Road, Pasadena, MD 21122		28. Kind of Business/Industry Fabrication	
29. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		30. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory Inc		31. Date of Disposition Date March 13 2012	
32. Location - City or Town, State Baltimore, Maryland					
33. Signature of Funeral Service Licensee ► [Signature]		34. Name and Address of Facility Stallings Funeral Home P.A. 3111 Mountain Road, Pasadena, MD 21122			
35. Approximate Interval Between Onset and Death					
36. Immediate Cause (Final disease or condition resulting in death)		37. Due to (or as a consequence of): Myocardial Infarction			
38. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		39. Due to (or as a consequence of): Atherosclerotic cardiovascular disease			
40. Due to (or as a consequence of):					
41. Due to (or as a consequence of):					
42. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		43. Was yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		44. Date of delivery Month Day Year	
45. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension Hyperlipidemia		46. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		47. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
48. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
49. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		50. Place of Death (Check only one) 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> OCA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		51. Date of delivery Month Day Year	
52. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		53. Date of injury (Month, Day, Year)		54. Time of injury M	
55. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		56. Describe how injury occurred		57. Location (Street and Number or Rural Route Number, City or Town, State)	
58. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
59. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician 2 <input type="checkbox"/> Medical Examiner 3 <input type="checkbox"/> Certifying Nurse Practitioner		60. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		61. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
62. Signature and title of certifier ► [Signature]		63. License number 025782		64. Date signed (Month, Day, Year) 03/09/2012	
65. Name and address of person who completed cause of death (Item 23a) (Type, Print) STEPHEN J ZZZI, MD 3550 BRIDGE HIGHWAY GLEN BURNIE MARYLAND					
66. Date filed (Month, Day, Year) MAR 13 2012		67. Registrar's signature [Signature]		68. Date signed (Month, Day, Year)	

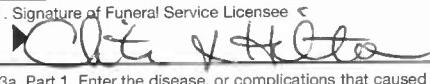
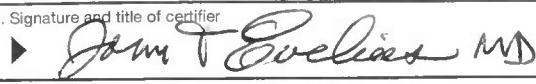
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07745

1 For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Matthew J. O'Rourke					2. Date of Death Month March Day 9 , Year 2012	3. Time of Death 8:30 AM			
	4a. Facility Name (if not institution, give street and number) 911 W. Lake Avenue			4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A				
Funeral Director	5. Social Security Number 117-12-9292		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 93 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) November 7, 1918	9. Birthplace (State or Foreign Country) New York		
	10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number 911 West Lake Avenue			10f. Zip Code 21210			10g. Citizen of What Country? USA			
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Roman Catholic Priest		16b. Kind of Business/Industry Church					
	17. Father's Name (First, Middle, Last) John O'Rourke					18. Mother's Name (First, Middle, Maiden Surname) Margaret Neary				
	19a. Informant's Name/Relationship (Type, Print) Fellow St. Joseph Society Sacred Heart Priest		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1130 N. Calvert Street Baltimore MD 21202							
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) New Cathedral Cemetery		Date 3/14/12	20c. Location - City or Town, State Baltimore Maryland				
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Leonard J. Ruck, Inc.		5305 Harford Road Baltimore, Maryland 21214				
Physician/ Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pneumonia								Approximate Interval Between Onset and Death Weeks	
	<p>a. Due to (or as a consequence of): Pneumonia</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year					
Medical Certificate: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
	5 Pending Investigation 6 Could not be determined									
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	29b. Signature and title of certifier 		29c. License number D 34952		29d. Date signed (Month, Day, Year) 3/9/2012					
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHN T. EVELIOS MD 7600 Osler Drive Suite 308 Towson MD 21204									
State Registrar	31. Date filed (Month, Day, Year) MAR 13 2012		32. Registrar's Signature 							

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07746

1- For
State
Registrar

Physician/
Medical
Examiner

Baltimore, Maryland 21215-0036
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

State
Registrar

1. Decedent's Name (First, Middle, Last) DELORES PAIGE		2. Date of Death Month: MARCH Day: 8 Year: 2012		3. Time of Death 8:45 P M
4a. Facility Name (if not institution, give street and number) Bradford Oaks Nursing Home		4b. City, Town, or Location of Death Clinton		4c. County of Death Prince Georges
5. Social Security Number 577-44-4248		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) 79 Yrs.	If Under 1 Year Months Days Hours Min. If Yes, Give Year or Dates.
8. Date of Birth (Month, Day, Year) Mar. 8, 1933		9. Birthplace (State or Foreign Country) DC		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
10a. State MD		10b. County Prince Georges		10c. City, Town or Location Clinton
10e. Street and Number 7520 Surratts Road		10f. Zip Code 20735		10g. Citizen of What Country? USA
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Retailer		16b. Kind of Business/Industry Herman's Sporting Goods
17. Father's Name (First, Middle, Last) Francis Sembly		18. Mother's Name (First, Middle, Maiden Surname) Mathilda Manne		
19a. Informant's Name/Relationship (Type, Print) Kenneth Sembly - Brother		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8104 Summitwood Ct. Clinton, MD 20735		
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		Date 3-12-2012
21. Signature of Funeral Service Licensee Victorine P. Lebold		22. Name and Address of Facility Marshall-March Funeral Home of Maryland 4308 Suitland Rd. Suitland, MD 20746		20c. Location - City or Town, State Alexandria, VA.
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Chronic Renal Failure				Approximate Interval Between Onset and Death
Sequentially list conditions, if any, leading to Immediate Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Failure to Thrive		Due to (or as a consequence of):		
{ b. c. d. Sequentially list conditions, if any, leading to Immediate Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dementia		Due to (or as a consequence of):		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Depression		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: X Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year) 28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number D0052999		29d. Date signed (Month, Day, Year) 3/12/2012
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ali Rahimian, MD 10403 Hospital Dr. G-06 Clinton, MD 20735		31. Date filed (Month, Day, Year) MAR 13 2012		
32. Signer's Signature J. Rahimian, MD		33. Signer's Signature Susan S. Parker		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07747

1- For
State
RegistrarPhysician/
Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/
Medical
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month March Day 11 Year 2012				3. Time of Death 5:10 P M	
Harry Pope							
4a. Facility Name (if not institution, give street and number) 4½ Horizon Circle, Apt. 1		4b. City, Town, or Location of Death Pikesville				4c. County of Death Baltimore	
5. Social Security Number 217-52-5515		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 62 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month Day Year) 07/03/1949	9. Birthplace (State or Foreign Country) MD
10a. State MD		10b. County Baltimore		10c. City, Town or Location Pikesville			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number 4½ Horizon Circle, Apt. 1		10f. Zip Code 21208			10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed) 12th grade		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Armed Security Officer		16b. Kind of Business Industry Wackenhut Corp.			
17. Father's Name (First, Middle, Last) Julian Pope, Sr.		18. Mother's Name (First, Middle, Maiden Surname) Minnie Lawrence					
19a. Informant's Name/Relationship (Type, Print) Rose E. Pope (Wife)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4½ Horizon Circle Apt. 1 Pikesville MD 21208					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest VA		Date 03/20/2012	20c. Location - City or Town, State Dwings Mills, MD		
21. Signature of Funeral Service Licensee ► Vaughn C. Greene		22. Name and Address of Facility Vaughn C. Greene Funeral Services 8728 Liberty Road Randallstown MD 21133					
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown			Approximate Interval Between Onset and Death
23d. Date of delivery Month Day Year		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
23f. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		23g. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier ► Syed Abbas MD		29c. License number D72139	29d. Date signed (Month, Day, Year) March 12 th 2012		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N Charles Street Suite 4105 Baltimore MD 21204.		31. Date filed (Month Day Year) MAR 13 2012		32. Registrar's signature Renata R. Jones			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07748

1-For State
Registrar**Physician/
Medical Examiner**

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death 0315 hrs
Kristin M. Putaro	March 11, 2012	

4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Atlantic General Hospital	Berlin	Worcester

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	B. Date of Birth (MM/DD/YYYY)	9. Birthplace (State or Foreign Country)
219-17-6654	1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	29	Yrs.	Months Days Hours Min.	04/17/1982	PA

Usual Residence of Decedent		10c. City, Town or Location	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
10a. State MD	10b. County Worcester	Ocean City	

10e. Street and Number 113 Seventy-Fourth Street	10f. Zip Code 21842	10g. Citizen of What Country? U.S.A.
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11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify:	14. Race - American Indian, Black, White, etc. Specify: White
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	If Yes, Give Year or Dates:		

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)	College (1-4 or 5+) 4	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Foster Care	16b. Kind of Business/Industry Worcester Co.
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17. Father's Name (First, Middle, Last) Joseph M. Putaro	18. Mother's Name (First, Middle, Maiden Surname) Kathleen S. Koerber
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19a. Informant's Name/Relationship (Type, Print) Joseph M. Putaro	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1202 Fox Terrier Dr., Bethel Park, PA 15102
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20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State	20b. Place of Disposition (Name of cemetery, crematory or other place) Pitts. Crem. Ser.	Date 3/15/12	20c. Location - City or Town, State Pittsburgh, PA
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:			

21. Signature of Funeral Service Licensed <i>BSW</i>	22. Name and Address of Facility Harman Funeral Service 7221 Grayburn Dr., Glen Burnie, MD 21061
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23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Pulmonary Thromboembolism Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Right Leg Deep venous Thromboses Due to (or as a consequence of):
	c. Right Ankle Injury Due to (or as a consequence of):

d.	
<input type="checkbox"/> UNPENDED	<input type="checkbox"/> AMENDED

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input checked="" type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
	24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No

25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA	Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other:
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27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day, Year) FOUND: Mar 11, 2012	28b. Time of Injury UNKNOWN	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred Subject twisted ankle
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Unknown		28f. Location (Street and Number or Rural Route Number, City or Town, State) Unknown, ,	

29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) March 12, 2012
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30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
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31. Date filed (Month, Day, Year) MAR 13 2012	32. Registrar's Signature <i>Janice A. Parker</i>
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07749

1- For
State
Registrar

Physician/
Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) Vito Russell Pipitone							2. Date of Death Month Day Year March 11 2012	3. Time of Death Hour Minute 0738 M
4a. Facility Name (if not institution, give street and number) Good Samaritan Hospital				4b. City, Town, or Location of Death Baltimore			4c. County of Death N/A	
5. Social Security Number 219-05-1274		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	Min.	8. Date of Birth Month Day Year June 28 1921	9. Birthplace (State or Foreign Country) Maryland
10a. State Maryland				10b. County Baltimore			10c. City, Town or Location Baltimore	
10e. Street and Number 3757 Proctor Lane				10f. Zip Code 21236			10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates. 8			13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Foreman			16b. Kind of Business Industry Railroad	
17. Father's Name (First, Middle, Last) Joseph Pipitone				18. Mother's Name (First, Middle, Maiden Surname) Mary Cicero				
19a. Informant's Name/Relationship (Type, Print) John Pipitone / Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3757 Proctor Lane, Baltimore, Maryland 21236				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Dulaney Valley Mem. Gdns				20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Mem. Gdns			Date 3/14/2012	20c. Location - City or Town, State Timonium, Maryland
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204				

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part 2. Enter the disease, or complications that contributed to the death but did not result in the underlying cause given in Part I. Arteriosclerosis		Approximate Interval Between Onset and Death
<p>a. Due to (or as a consequence of): Arteriosclerosis</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Arteriosclerosis				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOD Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		23f. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
		28d. Describe how injury occurred	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number H59540		29d. Date signed (Month, Day, Year) March 11, 2012
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Terry Murray				
31. Date filed (Month, Day, Year) MAR 13 2012		32. Registrar's Signature James J. Parker		

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07750

1 - For State Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Edgar Ries</i>							2. Date of Death Month 03 Day 10 Year 2012	3. Time of Death 10:05 a.m.					
	4a. Facility Name (if not institution, give street and number) Oak Crest - Renaissance Gardens				4b. City, Town, or Location of Death Parkville			4c. County of Death Baltimore						
Funeral Director	5. Social Security Number 218-07-7593	6. Sex 1 X M 2 F	7. Age (In yrs. last birthday) 96 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	Min.	8. Date of Birth (Month, Day, Year) SEP 13, 1915	9. Birthplace (State or Foreign Country) Maryland						
To Be Completed by Funeral Director	10a. State MD	10b. County Baltimore	10c. City, Town or Location Parkville					10d. Inside City Limits 1 □ Yes 2 X No						
	10e. Street and Number 8832 Walther Blvd., #3424				10f. Zip Code 21234			10g. Citizen of What Country? USA						
	11. Marital Status 1 □ Never Married 2 □ Married 3 X Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 X No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No) 1 □ Yes 2 X No Specify:			14. Race - American Indian, Black, White, etc. White						
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 2 General Manager			16b. Kind of Business/Industry Engineering							
	17. Father's Name (First, Middle, Last) George F. Ries				18. Mother's Name (First, Middle, Maiden Surname) Gertrude M. Richardson									
	19a. Informant's Name/Relationship (Type, Print) Wayne E. Ries, son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 79 Senoia Place, Apt. 207 Lynchburg, VA 24502									
Physician/ Medical Examiner	20a. Method of Disposition 1 □ Burial 2 X Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc.			Date 03/13/12	20c. Location - City or Town, State Baltimore, MD						
Medical Certificate: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee George MacNabb ▶ Seez E M MacNabb				22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228									
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death)				Approximate Interval Between Onset and Death									
	<p>a. Due to (or as a consequence of): Acute Myocardial Infarction</p> <p>b. Due to (or as a consequence of): Arteriosclerotic Cardiovascular Disease</p> <p>c. Due to (or as a consequence of):</p> <p>d. _____</p>													
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		23c. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown					23d. Date of delivery Month Day Year						
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 X No 3 □ Probably 4 □ Unknown						
								24a. Was an autopsy performed? 1 □ Yes 2 X No			24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No			
	25. Was case referred to medical examiner? 1 □ Yes 2 X No		26. Place of Death (Check only one) Hospital: 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 X Nursing Home 5 □ Residence 6 □ Other (Specify)					27. Manner of Death 1 X Natural 5 □ Pending Investigation 2 □ Accident 6 □ Could not be determined 3 □ Suicide 4 □ Homicide			28a. Date of injury (Month, Day, Year) 28b. Time of injury M		28c. Injury at work? 1 □ Yes 2 □ No	28d. Describe how injury occurred
								28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 □ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							29c. License number H 0052365		29d. Date signed (Month, Day, Year) 03-11-2012				
	29b. Signature and title of certifier ▶ Ronald Jeffreys													
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ronald Jeffreys 8800 Walther Blvd. Parkville, MD 21234													
	31. Date filed (Month, Day, Year) MAR 13 2012		32. Registrar's Signature ▶ Ronald Jeffreys											

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2012 07751

Reg. No.

1- For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Ronald Gano Roll				2. Date of Death Month: March Day: 11 , Year: 2012	3. Time of Death 9:05 P M	
	4a. Facility Name (if not institution, give street and number) The Arbor at BayWoods		4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arundel		
Funeral Director	5. Social Security Number 448-12-9055 Usual Residence of Decedent	6. Sex 1 X M 2 F	7. Age (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) AUG 25, 1924	9. Birthplace (State or Foreign Country) Oklahoma
To Be Completed by Funeral Director	10a. State MD	10b. County Anne Arundel	10c. City, Town or Location Annapolis			10d. Inside City Limits 1 □ Yes 2 X No	
	10e. Street and Number 7101 Bay Front Drive, Apt. 224			10f. Zip Code 21403		10g. Citizen of What Country? USA	
	11. Marital Status 1 □ Never Married 2 X Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates. WW II & Korea	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 X No Specify:	14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Physicist	16b. Kind of Business/Industry The Johns Hopkins Applied Physics Lab.			
	17. Father's Name (First, Middle, Last) Clyde Cecil Roll			18. Mother's Name (First, Middle, Maiden Surname) Fay Thorlton			
	19a. Informant's Name/Relationship (Type, Print) Ruth M. Roll, wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7101 Bay Front Drive, Apt. 224 Annapolis, MD 21403			
	20a. Method of Disposition 1 □ Burial 2 X Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc.	Date 03/13/12	20c. Location - City or Town, State Baltimore, MD		
	21. Signature of Funeral Service Licensee George MacNabb <i>George E MacNabb</i>		22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228				
Physician/ Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		<i>Dementia</i> a. Due to (or as a consequence of):		Approximate Interval Between Onset and Death 4 years		
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. Due to (or as a consequence of):				
			c. Due to (or as a consequence of):				
			d. Due to (or as a consequence of):				
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		23c. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown	23d. Date of delivery Month Day Year			
Medical Certificate: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Coronary artery Disease				23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 X No 3 □ Probably 4 □ Unknown		
					24a. Was an autopsy performed? 1 □ Yes 2 X No		
					24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No		
	25. Was case referred to medical examiner? 1 □ Yes 2 X No		26. Place of Death (Check only one) Hospital: 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 X Nursing Home 5 □ Residence 6 □ Other (Specify)				
	27. Manner of Death 1 X Natural 5 □ Pending Investigation 2 □ Accident 6 □ Could not be determined 3 □ Suicide 4 □ Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 □ Yes 2 □ No		
			28d. Describe how injury occurred				
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 □ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
	29b. Signature and title of certifier <i>Paul Berez MD</i>		29c. License number D 0029571		29d. Date signed (Month, Day, Year) 03/12/2012		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul B. Berez, MD 2200 Defense Hwy, Ste 103, Crofton MD 21114						
State Registrar	31. Date filed (Month, Day, Year) MAR 13 2012		32. Registrar's Signature <i>James S. Baker</i>				

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07752

1 - For
State
RegistrarPhysician/
Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

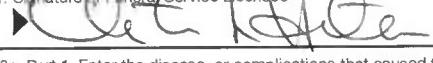
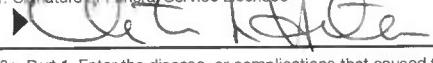
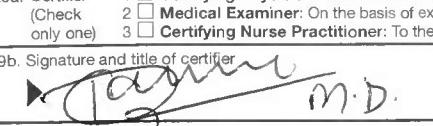
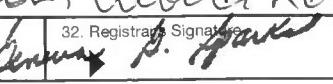
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
Medical
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6pm
State
Registrar

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death 8:20 P.M.
Eileen H. Ryan			March 6, 2012	
4a. Facility Name (if not institution, give street and number) Genesis Eldercare Hamilton			4b. City, Town, or Location of Death Baltimore City	4c. County of Death N/A
5. Social Security Number 218-44-5445		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 67 Yrs.	8. Date of Birth (Month, Day, Year) February 17, 1945
9. Usual Residence of Decedent Maryland		10a. State Maryland	10b. County N/A	10c. City, Town or Location Baltimore
10e. Street and Number 6040 Harford Road			10f. Zip Code 21214	10g. Citizen of What Country? USA
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 4 Computer Analyst	16b. Kind of Business/Industry Telecommunications	
17. Father's Name (First, Middle, Last) Thomas G. Ryan, Sr.			18. Mother's Name (First, Middle, Maiden Surname) Irene Bontz	
19a. Informant's Name/Relationship (Type, Print) John C. Ryan/Brother			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1893 Ingleside Terrace N.W. Washington, D.C. 20010	
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) 		20b. Place of Disposition (Name of cemetery, crematory or other place) Prospect Hill	Date 3/13/12	20c. Location - City or Town, State Towson, MD
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Rd.	Baltimore, Maryland 21214	
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
<p>a. Due to (or as a consequence of): <i>CVA</i></p> <p>b. Due to (or as a consequence of): <i>Respiratory Failure</i></p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>				
Approximate Interval Between Onset and Death				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28d. Describe how injury occurred	
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier  29c. License number DD0070076		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8813 Walham Woods Rd, Parmailler, MD-21234		29d. Date signed (Month, Day, Year) 03/07/12		
31. Date filed (Month, Day, Year) MAR 13 2012		32. Registrar's Signature 		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07753

1 For
State
RegistrarPhysician/
Medical
ExaminerFuneral
Director

Baltimore, Maryland 21215-0036

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) Charles Burton Richardson			2. Date of Death Month Day Year 3-9-2012	3. Time of Death 1801 M
4a. Facility Name (if not institution, give street and number) Gilchrist Hospice			4b. City, Town, or Location of Death Baltimore	
4c. County of Death				
5. Social Security Number 213-58-3359		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 59 Yrs.	If Under 1 Year Months Days Hours Min. If Under 24 Hrs. Specify:
8. Date of Birth (Month, Day, Year) 1-24-1953		9. Birthplace (State or Foreign Country) MD		
10a. State MD		10b. County		10c. City, Town or Location Baltimore
10e. Street and Number 1408 Southern Avenue			10f. Zip Code 21214	
10g. Citizen of What Country? USA				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
15. Decedent's Education (Specify only highest grade completed) 11th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Uphosterer		16b. Kind of Business/Industry Self-Employed
17. Father's Name (First, Middle, Last) Isaac Richardson		18. Mother's Name (First, Middle, Maiden Surname) Anita Richardson		
19a. Informant's Name/Relationship (Type, Print) Brother Jeffrey Richardson		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5907 Sherandoah Rd, Greensboro, NC 27405		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery		Date 3/17/2012
21. Signature of Funeral Service Licensee JG MO1553		22. Mailing Address of Facility Daugherty Greene Funeral Services 4907 York Rd - Baltimore MD 21212		
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): Metastatic lung cancer				
b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		
23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
23e. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice		
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred
				28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier John		
		29c. License number D71040		29d. Date signed (Month, Day, Year) 3/10/12
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) APATHI KUMAR 6701 N CHARLES ST SUITE 4105 BALTIMORE MD				
31. Date filed (Month, Day, Year) MAR 13 2012		32. Registrar's Signature Leanne A. Park		

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5pm
State
Registrar

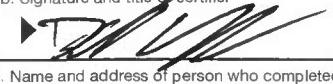
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07754

1 - For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) JEAN RUBY			2. Date of Death 03 07 2012			3. Time of Death 0602 AM		
	4a. Facility Name (if not institution, give street and number) UNIVERSITY OF MARYLAND MEDICAL CENTER			4b. City, Town, or Location of Death BALTIMORE			4c. County of Death		
Funeral Director	5. Social Security Number 212-26-0040	6. Sex M	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months 	If Under 24 Hrs. Days 	8. Date of Birth (Month, Day, Year) Nov. 20, 1928	9. Birthplace (State or Foreign Country) Maryland		
To Be Completed by Funeral Director	10a. State Maryland		10b. County Baltimore	10c. City, Town or Location Baltimore				10d. Inside City Limits X Yes	
	10e. Street and Number 1125 Bayard St.			10f. Zip Code 21223			10g. Citizen of What Country? United States		
	11. Marital Status Never Married		12. Was Decedent Ever in U.S. Armed Forces? Yes	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) No			14. Race - American Indian, Black, White, etc. White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)			16b. Kind of Business/Industry Binder Printing			
	17. Father's Name (First, Middle, Last) Elmer Innerst			18. Mother's Name (First, Middle, Maiden Surname) Gertrude Sheild					
	19a. Informant's Name/Relationship (Type, Print) Violet Ruby - Daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1125 Bayard St., Baltimore, Maryland 21223					
	20a. Method of Disposition Burial			20b. Place of Disposition (Name of cemetery, crematory or other place) Atlantic Crematory	Date Mar. 11, 2012		20c. Location - City or Town, State Glen Burnie, Maryland		
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility AMBROSE FUNERAL HOME OF LANSDOWNE 2719 Hammonds Ferry Rd., Lansdowne, Maryland 21227					
Physician/ Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CORONARY ARTERY DISEASE								
	Approximate Interval Between Onset and Death								
	a. Due to (or as a consequence of): CORONARY ARTERY DISEASE								
	b. Due to (or as a consequence of): 								
	c. Due to (or as a consequence of): 								
	d. Due to (or as a consequence of): 								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? Yes								
	23c. If yes, outcome of pregnancy Live Birth								
	23d. Date of delivery Month Day Year								
	24. Did tobacco use contribute to the cause of death? No								
	24a. Was an autopsy performed? No								
	24b. Were autopsy findings available prior to completion of cause of death? No								
	25. Was case referred to medical examiner? Yes								
	26. Place of Death (Check only one) Hospital: Inpatient								
	Other: Nursing Home								
	27. Manner of Death Natural								
	28a. Date of injury (Month, Day, Year) 								
	28b. Time of injury M								
	28c. Injury at work? Yes								
	28d. Describe how injury occurred 								
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 								
	28f. Location (Street and Number or Rural Route Number, City or Town, State) 								
	29a. Certifier Certifying Physician : To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner : On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Nurse Practitioner : To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
	29b. Signature and title of certifier  DAVID WACKER MD								
	29c. License number 1386969327								
	29d. Date signed (Month, Day, Year) MARCH 07, 2012								
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID WACKER MD 1105 PACA STREET SUITE 200, BALTIMORE MD 21201								
	31. Date filed (Month, Day, Year) MAR 13 2012								
	32. Registrar's Signature 								

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit

6v

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. EOTL 07700

2012 07755

Physician/ Medical Examiner		Helen G. Rigler						Date of Death Month 03 Day 10 Year 1951 PM	Time of Death 1951 PM	
Funeral Director		Mercy Medical Center			Baltimore City		County of Death MD			
To Be Completed by Funeral Director		Social Security Number 215-22-2252		Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	Age (In yrs. last birthday) 93 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	Date of Birth (Month, Day, Year) 10/18/1918	Birthplace (State or Foreign Country) USA	
		Usual Residence of Decedent MD Baltimore		10c. City, Town or Location Parkton			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
		Street and Number 9 Patrick's Court		Zip Code 21120			Citizen of What Country? USA			
		Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.			Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			Race - American Indian, Black, White, etc. Specify: white
		Elementary/Secondary (0-12)		College (1-4 or 5+) 4			Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) elementary teacher			Kind of Business/Industry education
		Father's Name (First, Middle, Last) C. Ross Gill					Mother's Name (First, Middle, Maiden Surname) Iova Peregoy			
		Informant's Name/Relationship (Type, Print) Sue Rigler Gaston, daughter		Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Patrick's Court, Parkton, MD 21120						
		Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) Hampstead Cemetery		Place of Disposition (Name of cemetery, crematory or other place) Hampstead Cemetery			Date 3/14/2012	Location - City or Town, State Hampstead, MD		
Signature of Funeral Service Licensee ► Paula L. Lemmar		Name and Address of Facility MO0741 Eline Funeral Home 934 S. Main Street, Hampstead, MD 21074								
Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death congestive heart failure								
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. Due to (or as a consequence of):								
		b. Due to (or as a consequence of):								
		c. Due to (or as a consequence of):								
		d. Due to (or as a consequence of):								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____			Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. atherosclerotic cardiovascular disease					Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		Date of injury (Month, Day, Year)		Time of injury M	Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	Describe how injury occurred				
		Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		Location (Street and Number or Rural Route Number, City or Town, State)						
Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
Signature and title of certifier ► C.R.		License number P27349			Date signed (Month, Day, Year) 03, 10, 2012					
Name and address of person who completed cause of death (Item 23a) (Type, Print) CARA MORIN, MD					301 St. Paul Place, Baltimore, MD 21202					
Date filed (Month, Day, Year) MAR 13 2012		Registrar's Signature Leanne J. Baker								

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07756

1 - For
State
RegistrarPhysician/
Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/
Medical
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death
John Leonard Roadside		March 09, 2012		11:30AM
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
208 Kings Crossing, 2B		Bel Air		Harford
5. Social Security Number	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 80 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 12/17/1931
200-24-6529 Usual Residence of Decedent				9. Birthplace (State or Foreign Country) Pennsylvania
10a. State MD	10b. County Harford	10c. City, Town or Location Bel Air		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number 208 Kings Crossing, 2B		10f. Zip Code 21014		10g. Citizen of What Country? U.S.A.
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: White	14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Carpenter		16b. Kind of Business/Industry Construction
17. Father's Name (First, Middle, Last) Metro Roadside		18. Mother's Name (First, Middle, Maiden Surname) Anna Simpson		
19a. Informant's Name/Relationship (Type, Print) Sheila Roadside / Spouse		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 208 Kings Crossing, 2B, Bel Air, MD 21014		
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Anatomy Gifts Registry	Date 03/13/2012	20c. Location - City or Town, State Hanover, Maryland
21. Signature of Funeral Service Licensee ► <i>BOC</i>		22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076		
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death weeks
23c. If female: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year		
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number DS3186		
29b. Signature and title of certifier ► <i>Jill G. Tinney MD</i>		29d. Date signed (Month, Day, Year) March 9, 2012		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Jill G. Tinney MD 754 N Hickory Ave Bel Air MD 21014</i>				
31. Date filed (Month, Day, Year) MAR 13 2012		32. Registrar's Signature <i>Constance J. Farrel</i>		

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. **2012 07757**

1 - For State Registrar

**Physician/
Medical
Examiner**

Baltimore, Maryland 21215-0036
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified once.
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) Betty Jo Richardson							2. Date of Death Month: March Day: 7 Year: 2012	3. Time of Death Hour: 3:00 AM Min: 2:45 p.m.			
4a. Facility Name (if not institution, give street and number) 10426 Hayes Avenue				4b. City, Town, or Location of Death Silver Spring			4c. County of Death Montgomery				
5. Social Security Number 264-94-9351		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 60 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	Min.	8. Date of Birth (Month, Day, Year) July 22, 1951	9. Birthplace (State or Foreign Country) Florida			
Usual Residence of Decedent 10a. State MD			10b. County Montgomery			10c. City, Town or Location Silver Spring			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 10426 Hayes Ave.				10f. Zip Code 20902			10g. Citizen of What Country? United States				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: Black			14. Race - American Indian, Black, White, etc. Specify: Black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 4 Registered Nurse			16b. Kind of Business/Industry Health Care					
17. Father's Name (First, Middle, Last) Nathaniel Sanderson				18. Mother's Name (First, Middle, Maiden Surname) Willie Mae McClain							
19a. Informant's Name/Relationship (Type, Print) Joseph M. Richardson (husband)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10426 Hayes Ave. Silver Spring, Maryland 20902							
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory			Mar. Date 2012 10	20c. Location - City or Town, State Beltsville, MD.				
21. Signature of Funeral Service Licensee ► D. Johnson			22. Name and Address of Facility Rapp Funeral & Cremation Service 933 Gist Ave. Silver Spring, Maryland 20910								
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)				Approximate Interval Between Onset and Death							
a. Breast Cancer Due to (or as a consequence of):											
b. _____ Due to (or as a consequence of):											
c. _____ Due to (or as a consequence of):											
d. _____											
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA			Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Pending Investigation 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number D 39505						29d. Date signed (Month, Day, Year) March 9, 2012			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Yudhish Manoranjan 305 Hospital Dr, Glen Burnie, MD 21061											
31. Date filed (Month, Day, Year) MAR 13 2012				32. Registrar's Signature Anna J. Garcia							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07758

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) William M. Robinson				2. Date of Death Month 03 Day 06 Year 2012		3. Time of Death 2:00 PM					
Funeral Director		4a. Facility Name (if not institution, give street and number) 3411 24th Avenue				4b. City, Town, or Location of Death Temple Hills		4c. County of Death Prince George's					
To Be Completed by Funeral Director		5. Social Security Number 223-34-4668		6. Sex M		7. Age (In yrs. last birthday) 77 Yrs.		If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) 08-15-1934	9. Birthplace (State or Foreign Country) VA		
		Usual Residence of Decedent 10a. State MD		10b. County Prince George's		10c. City, Town or Location Temple Hills				10d. Inside City Limits Yes			
		10e. Street and Number 3411 24th Avenue				10f. Zip Code 20748		10g. Citizen of What Country? USA					
		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates. Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: X		14. Race - American Indian, Black, White, etc. Specify: Black					
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) I-4				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired) Producer		16b. Kind of Business Industry Federal Gov't					
		17. Father's Name (First, Middle, Last) Charlie Robinson				18. Mother's Name (First, Middle, Maiden Surname) Leona Williams							
		19a. Informant's Name/Relationship (Type, Print) Barbara P. Robinson / Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3411 24th Ave., Temple Hills, MD 20748							
		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) X				20b. Place of Disposition (Name of cemetery, crematory or other place) Lincoln Mem. Cem.		Date 03-12-2012	20c. Location - City or Town, State Suitland, MD				
		21. Signature of Funeral Service Licensee Tisha R. Reid				22. Name and Address of Facility Cedar Hill FH, Inc., 4111 PA Ave., Suitland, MD							
Physician/ Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pancreas cancer								Approximate Interval Between Onset and Death			
		23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown											
		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____								23d. Date of delivery Month Day Year			
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
		Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA				Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)			
		29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
		29b. Signature and title of certifier Martin Weltz MD								29c. License number D23743			
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Martin Weltz 7525 Greenway Ct Dr Greenbelt MD								29d. Date signed (Month, Day, Year) Mar 12 2012			
State Registrar		31. Date filed (Month, Day, Year) MAR 13 2012								32. Registrar's Signature J. Baker			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07759

1- For
State
Registrar

Physician/
Medical
Examiner

To Be Completed by Funeral Director

Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death 8:00 P M	
Don Terry Scott		March 11, 2012					
4a. Facility Name (if not institution, give street and number) 4201 Pennington Avenue, Apt. 209		4b. City, Town, or Location of Death Baltimore				4c. County of Death N/A	
5. Social Security Number 357-42-3298		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 59 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) July 10, 1952	9. Birthplace (State or Foreign Country) District of Columbia
Usual Residence of Decedent 10a. State MD		10b. County N/A		10c. City, Town or Location Baltimore		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number 4201 Pennington Avenue, Apt. 209		10f. Zip Code 21226				10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates. Vietnam		13. Was Decedent of Hispanic Origin? (Specify Yes or No) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: 14. Race - American Indian, Black, White, etc. Specify: Black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 2		16b. Kind of Business/Industry Police Officer Law Enforcement			
17. Father's Name (First, Middle, Last) Ollie Joseph Scott		18. Mother's Name (First, Middle, Maiden Surname) Daisy Lee Graves					
19a. Informant's Name/Relationship (Type, Print) Alicia M. Scott, wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 Bayside Drive Dundalk, Maryland 21222					
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) Metro Crematory, Inc.		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc.		Date 03/12/12	20c. Location - City or Town, State Baltimore, MD		
21. Signature of Funeral Service Licensee George MacNabb		22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228					
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		myocardial infarction				Approximate Interval Between Onset and Death	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. Due to (or as a consequence of): coronary artery disease	b. Due to (or as a consequence of):	c. Due to (or as a consequence of):	d. _____		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number D0034650				29d. Date signed (Month, Day, Year) March 12, 2012	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jeffrey A. Cool, M.D. 5009 Honeygo Center Drive, Ste 216 Perry Hall, MD 21128							
31. Date and Month Year MAR 13 2012		32. Registrar's Signature Lorraine J. Gossel					

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07760

1 - For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary C. Spadaro					2. Date of Death Month March Day 8 , Year 2012 Time 9:15 P.M.	3. Time of Death
	4a. Facility Name (if not institution, give street and number) Stella Maris					4b. City, Town, or Location of Death Timonium	4c. County of Death Baltimore
Funeral Director	5. Social Security Number 220-12-5924	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) 87 Yrs.	If Under 1 Year Months <input type="checkbox"/>	If Under 24 Hrs. Days <input type="checkbox"/>	8. Date of Birth (Month, Day, Year) April 14, 1924	9. Birthplace (State or Foreign Country) Balt., Maryland
	10a. State Maryland 10b. County Baltimore 10c. City, Town or Location Towson					10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number 212 Aigburth Road			10f. Zip Code 21286	10g. Citizen of What Country? United States of America		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Personal Benefits Specialist		16b. Kind of Business/Industry Baltimore County Police Department			
	17. Father's Name (First, Middle, Last) Clifton Sunderland			18. Mother's Name (First, Middle, Maiden Surname) Frieda Heurich			
	19a. Informant's Name/Relationship (Type, Print) Nancy S. Weintraub/ daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 324 Dixie Drive Towson, Maryland 21204			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Evans Funeral Chapel Bel Air			20b. Place of Disposition (Name of cemetery, crematory or other place) Evans Funeral Chapel Bel Air	Date March 10, 2012	20c. Location - City or Town, State Forest Hill, Maryland	
	21. Signature of Funeral Service Licensee J. Lopez B.M.			22. Name and Address of Facility Peaceful Alternatives Funeral and Cremation Center, P.A. 2325 York Road Timonium, Maryland 21093			
Physician/ Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CONGESTIVE HEART FAILURE Due to (or as a consequence of): AORTIC STENOSIS Due to (or as a consequence of): HYPERTENSION Due to (or as a consequence of): CHRONIC OBSTRUCTIVE PULMONARY DISEASE Approximate Interval Between Onset and Death						
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown						
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Medical Certificate: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide						
	28a. Date of injury (Month, Day, Year) 28b. Time of injury M 28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No 28d. Describe how injury occurred						
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						
	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	29a. Certifier <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
	29b. Signature and title of certifier Junecia White CRNP License number R127474 Date signed (Month, Day, Year) 3/9/12						
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JUNECIA WHITE, CRNP 2300 DULANEY VALLEY ROAD TIMONIUM MD 21093						
	31. Date filed (Month, Day, Year) MAR 13 2012 32. Registrar's Signature Junecia White						

ORIGINAL

9:15 P.M.

MARCH 8, 2012 Baltimore, Maryland 21215-0036

Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

SPADARO, JUNECIA WHITE, CRNP, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07761

1 - For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Martin Eugene Stumbroski, Sr.					2. Date of Death Month March Day 09 , Year 2012	3. Time of Death 10:30 PM		
	4a. Facility Name (if not institution, give street and number) Gilchrist Center					4b. City, Town, or Location of Death Towson	4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 219-16-6836	6. Sex 1 X M 2 □ F	7. Age (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Feb. 24, 1925	9. Birthplace (State or Foreign Country) Baltimore, MD		
	10a. State MD 10b. County Baltimore 10c. City, Town or Location Carney					10d. Inside City Limits 1 □ Yes 2 X No			
To Be Completed by Funeral Director	10e. Street and Number 3304 Glenside Drive			10f. Zip Code 21234		10g. Citizen of What Country? United States			
	11. Marital Status 1 □ Never Married 2 X Married 3 □ Widowed 4 □ Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates. WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 X No Specify:		14. Race - American Indian, Black, White, etc. White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Supervisor		16b. Kind of Business/Industry Federal Government			
	17. Father's Name (First, Middle, Last) Joseph Felix Stumbroski			18. Mother's Name (First, Middle, Maiden Surname) Frances Mary Ablamowicz					
Physician/ Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Gustava Stumbroski- Wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3304 Glenside Drive Carney, Maryland 21234					
	20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Parkwood Cemetery		Date March 13, 2012	20c. Location - City or Town, State Parkville, Maryland		
Medical Certificate: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee John W. Evans			22. Name and Address of Facility Evans Funeral Chapel & Cremation Services 8800 Harford Rd. Parkville, MD 21234					
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)			Approximate Interval Between Onset and Death Unknown					
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown			23c. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (Specify) 9 □ Unknown		23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			23e. Did tobacco use contribute to the cause of death? 1 X Yes 2 □ No 3 □ Probably 4 □ Unknown					
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	25. Was case referred to medical examiner? 1 □ Yes 2 X No			26. Place of Death (Check only one) Hospital: 1 □ Inpatient 2 □ ER/Outpatient 3 □ DDA Other: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)		23f. Was an autopsy performed? 1 □ Yes 2 X No		24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No	
	27. Manner of Death 1 X Natural 5 □ Pending Investigation 2 □ Accident 6 □ Could not be determined 3 □ Suicide 4 □ Homicide			28a. Place of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 □ Yes 2 □ No	28d. Describe how injury occurred Hospital		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 □ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29c. License number MD D71040					29d. Date signed (Month, Day, Year) 3 / 10 / 12	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) APATHI KUMAR 6701 N Charles St Suite 4105 BALTIMORE MD									
31. Date filed (Month, Day, Year) MAR 13 2012			32. Registrar's Signature Suman J. Patel						

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07762

1 - For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Jueri Soots				2. Date of Death Month Day Year March 10, 2012	3. Time of Death 4:00 AM							
	4a. Facility Name (if not institution, give street and number) Gilchrist Hospice Center				4b. City, Town, or Location of Death Towson	4c. County of Death Baltimore							
Funeral Director	5. Social Security Number 219-40-8225	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 69 Yrs.	If Under 1 Year Months Days Hours Min. 	8. Date of Birth (Month, Day, Year) March 16, 1942	9. Birthplace (State or Foreign Country) Estonia							
	Usual Residence of Decedent Maryland Baltimore				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
To Be Completed by Funeral Director	10a. State Maryland			10b. County Baltimore	10c. City, Town or Location Parkton		10g. Citizen of What Country? United States of America						
	10e. Street and Number 19907 York Road			10f. Zip Code 21120			10h. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						
Physician/ Medical Examiner	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. White						
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 3 Electrician Consultant Engineer		16b. Kind of Business/Industry Soots Consultants			17. Father's Name (First, Middle, Last) Endel Soots	18. Mother's Name (First, Middle, Maiden Surname) Erika Brinkman				
Medical Certificate: To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Evelyn L. Soots - Spouse			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19907 York Road, Parkton, Maryland 21120									
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Wiseburg Cemetery		Date March 15, 2012	20c. Location - City or Town, State Parkton, Maryland						
21. Signature of Funeral Service Licensee Stacie L. Spahr			22. Name and Address of Facility Evans Funeral Chapel and Cremation Services - Monkton 16924 York Road, Monkton, Maryland 21111										
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)			Approximate Interval Between Onset and Death										
<p>a. Metastatic NonSmall Cell Cancer Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>													
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown						
							24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice					27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work? M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred		
											28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							29b. Signature and title of certifier ARAVIT KUMAR					29c. License number MD D 71040	29d. Date signed (Month, Day, Year) 3/10/12
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARAVIT KUMAR 6701 N CHARLES STREET SUITE 4105 BALTIMORE MD													
31. Date filed (Month, Day, Year) MAR 13 2012		32. Registrar's Signature Seneca J. Sauer											

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07763

1 - For
State
Registrar

Physician/
Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show
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To the Hospital or Attending Physician: The law requires that the death certificate be executed
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completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month March	3. Time of Death Day 07 Year 2012
Hazel V. Sorrentino			
4a. Facility Name (if not institution, give street and number) 121 Kingbrook Road		4b. City, Town, or Location of Death Linthicum	
4c. County of Death Anne Arundel			
5. Social Security Number 213-03-0260		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) 93 Yrs.
8. Usual Residence of Decedent Maryland Anne Arundel		9. If Under 1 Year Months	10. If Under 24 Hrs. Days Hours Min.
10a. State Maryland		10b. County Anne Arundel	
10c. City, Town or Location Linthicum		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 121 Kingbrook Road		10f. Zip Code 21090	10g. Citizen of What Country? USA

11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)	16b. Kind of Business/Industry Soc. Sec. Administration	
17. Father's Name (First, Middle, Last) Walter Raymond Ambrose Sr.	18. Mother's Name (First, Middle, Maiden Surname) Violet Yost		
19a. Informant's Name/Relationship (Type, Print) Ruth Holmes (Daughter)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 121 Kingbrook Rd. Linthicum, Md. 21090		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven Cem.	Date 3/10/12	20c. Location - City or Town, State Glen Burnie, Md.
21. Signature of Funeral Service Licensee 	22. Name and Address of Facility Stallings Funeral Home PA 3111 Mountain Rd. Pasadena, Md. 21122		

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	Approximate Interval Between Onset and Death years
a. Due to (or as a consequence of): Congestive Heart Failure	
b. Due to (or as a consequence of):	
c. Due to (or as a consequence of):	
d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Atrial Fibrillation	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
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25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)
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27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide	28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
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28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
--	--

29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	29c. License number D0033296	29d. Date signed (Month, Day, Year) 318/12
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Neil E Padgett MD	
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31. Date filed (Month, Day, Year) MAR 13 2012	32. Registrar's Signature 
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07764

1 - For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Alex Stamper</i>						2. Date of Death Month Day Year <i>03 08 2012</i>		3. Time of Death <i>1030 M</i>				
	4a. Facility Name (if not institution, give street and number) <i>Sinai Hospital of Baltimore</i>			4b. City, Town, or Location of Death <i>Baltimore City</i>			4c. County of Death						
Funeral Director	5. Social Security Number <i>212-70-7243</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>54 Yrs.</i>		If Under 1 Year Months Days Hours Min.		8. Date of Birth (Month, Day, Year) <i>11-14-1957</i>		9. Birthplace (State or Foreign Country) <i>MD</i>			
	Usual Residence of Decedent <i>3712 W. Cold Spring Lane</i>			10c. City, Town or Location <i>Baltimore</i>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						
To Be Completed by Funeral Director	10e. Street and Number <i>3712 W. Cold Spring Lane</i>			10f. Zip Code <i>21215</i>			10g. Citizen of What Country? <i>USA</i>						
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates. <i>1970</i>			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: <i>Black</i>			14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>			
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) <i>12th</i>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Correctional Officer</i>			16b. Kind of Business/Industry <i>Department of Corrections</i>						
	17. Father's Name (First, Middle, Last) <i>Charles Stamper</i>			18. Mother's Name (First, Middle, Maiden Surname) <i>Geraldine Martin</i>									
Medical Certificate: To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <i>James Antwan Stamper (Son)</i>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2325 Windsor Avenue, Balto., MD 21216</i>									
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) <i>Garrison Forest</i>			20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Garrison Forest</i>			Date <i>3-20-12</i>	20c. Location - City or Town, State <i>Owings Mills, MD</i>					
21. Signature of Funeral Service Licensee <i>Vaughn C. Greene</i>			22. Signature and address of Facility <i>Vaughn C. Greene Funeral Services 5151 Baltimore National Pike (21229)</i>										
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Anemia</i> Due to (or as a consequence of): <i>Diabetes Mellitus Type II</i> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>Malnutrition</i> Due to (or as a consequence of): <i>Coronary Artery disease</i>										Approximate Interval Between Onset and Death			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown						23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Cocaine abuse</i> <i>Hypertension</i> <i>Chronic kidney disease</i>										23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		23f. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year) <i>M</i>		28b. Time of injury M		28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29b. Signature and title of certifier <i>James Petit</i>						29c. License number <i>D0069485</i>		29d. Date signed (Month, Day, Year) <i>03-08-2012</i>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>James Petit 2407 Belvedere AVE Baltimore, MD 21215</i>													
31. Date filed (Month, Day, Year) <i>MAR 13 2012</i>		32. Registrar's Signature <i>J. Parker</i>											

Baltimore, Maryland 21215-0036
Permit: Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Fax to Me!
Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07765

1 - For
State
Registrar

Physician/
Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) Audrey J. Sauer							2. Date of Death Month 03 Day 07 Year 2012	3. Time of Death 2150M	
4a. Facility Name (if not institution, give street and number) Peninsula Regional Medical Center				4b. City, Town, or Location of Death Salisbury			4c. County of Death Wicomico		
5. Social Security Number 217-24-9346		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) 81 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	Min.	8. Date of Birth (Month, Day, Year) July 14, 1930	9. Birthplace (State or Foreign Country) Maryland	
10a. State Maryland		10b. County Worchester		10c. City, Town or Location Pocomoke City					10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
10e. Street and Number 422 Jones Road				10f. Zip Code 21851			10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home		
17. Father's Name (First, Middle, Last) William Ormond Haase					18. Mother's Name (First, Middle, Maiden Surname) Blanche G. Wilson				
19a. Informant's Name/Relationship (Type, Print) Audrey Whitehurst / Daughter					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2809 Sandy Hook Road, Forest Hill, MD 21050				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Gardens of Faith Cem.			Date 3/10/2012	20c. Location - City or Town, State Baltimore, Maryland		
21. Signature of Funeral Service Licensee Charles A. Enger				22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009					

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year		Approximate Interval Between Onset and Death
23e. Did tobacco use contribute to the cause of death? COPD Essential HTN		23f. Did tobacco use contribute to the cause of death? Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		23g. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		23h. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year) 28b. Time of injury M 28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number D0073139		29d. Date signed (Month, Day, Year) 03/08/12				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ASMAN ZULFIQAR 100 E-CARROLL ST, SALISBURY, MD		31. Date filed (Month, Day, Year) MAR 13 2012		32. Registrar's Signature Anna S. Paice				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

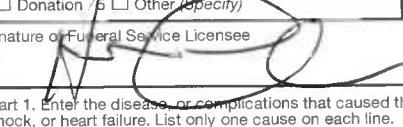
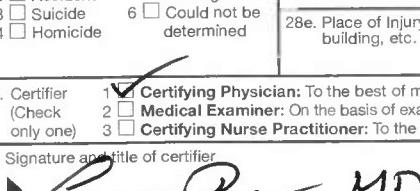
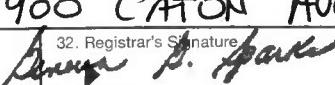
Certificate of Death

Reg. No.

2012 07766

1- For
State
Registrar

Physician/
Medical
Examiner

1. Decedent's Name (First, Middle, Last) James I. Sheppard		2. Date of Death Month MARCH Day 8 Year 2012		3. Time of Death 00:12 AM
4a. Facility Name (if not institution, give street and number) St. AGNES HOSPITAL		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A
5. Social Security Number 219-50-2420		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 64 Yrs.	If Under 1 Year Months Days Hours Min.
Usual Residence of Decedent 10a. State MD		10b. County N/A		10c. City, Town or Location Baltimore
10e. Street and Number 1533 W. Baltimore St., Apt. C		10f. Zip Code 21223		10g. Citizen of What Country? USA
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates. 12		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: African Amer.
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Plumber		16b. Kind of Business/Industry City Of Baltimore
17. Father's Name (First, Middle, Last) James I. Sheppard, Sr.		18. Mother's Name (First, Middle, Maiden Surname) Lucukke Dunaway		
19a. Informant's Name/Relationship (Type, Print) Jermaine Sheppard/Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1533 W. Balt., St., Balt., MD 21223		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Bayview Crematory		20b. Place of Disposition (Name of cemetery, crematory or other place) Bayview Crematory		Date 3/16/12
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Hari P. Close F Sys PA 5126 Belair Rd, Balt., MD 21206-5105		20c. Location - City or Town, State Balt., MD
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death YEARS		
a. END STAGE RENAL DISEASE Due to (or as a consequence of):				
b. CLOSTRIDIUM DIFFICILE DIARRHEA Due to (or as a consequence of):		DAYS		
c. Due to (or as a consequence of):				
d. Due to (or as a consequence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		23f. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier  MD		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SEKICKI VUK, 900 CATON AVENUE, BALTIMORE, MD 21229		29c. License number P25487		29d. Date signed (Month, Day, Year) MARCH, 8. 2012.
31. Date filed (Month, Day, Year) MAR 13 2012		32. Registrar's Signature 		

Baltimore, Maryland 21215-0036
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

SHEPPARD, JAMES
Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

State Registrar
DHMH 17 Rev 06-2011

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

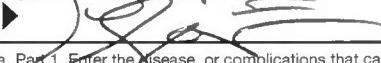
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2012 07767

Reg. No.

1 - For
State
RegistrarPhysician/
Medical
Examiner

1. Decedent's Name (First, Middle, Last) SONDRA F. STEINBERG			2. Date of Death Month March Day 8 Year 2012	3. Time of Death 09:40AM
4a. Facility Name (if not institution, give street and number) Sinai Hospital of Baltimore			4b. City, Town, or Location of Death Baltimore City	
4c. County of Death N/A				
5. Social Security Number 219-28-4105		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months Days Hours Min.
8. Date of Birth (Month, Day, Year) 04/02/1932		9. Birthplace (State or Foreign Country) MD		
10a. State MD		10b. County N/A		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
10c. City, Town or Location BALTIMORE			10e. Street and Number 7121 PARK HEIGHTS AVENUE, #901	
10f. Zip Code 21215			10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates. 		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT Use retired) BUSINESS OWNER		16b. Kind of Business/Industry FUR SALON
17. Father's Name (First, Middle, Last) BERNARD		18. Mother's Name (First, Middle, Maiden Surname) JEAN CRYSTAL		
19a. Informant's Name/Relationship (Type, Print) SIDNEY STEINBERG/SON		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 301 GYPSY LANE, WYNNEWOOD, PA 19096		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) BALTIMORE HEBREW CEM		Date 03/11/2012
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208		

Medical Certificate: To Be Completed by Physician/Medical Examiner

Physician/
Medical
Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		a. Right anterior cerebral & middle cerebral artery stroke Due to (or as a consequence of):		Approximate Interval Between Onset and Death 3 days.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. _____ Due to (or as a consequence of):		
c. _____ Due to (or as a consequence of):		d. _____		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Atrial fibrillation, chronic kidney disease, chronic obstructive pulmonary disease, obstructive sleep apnea.		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number RES-000		
29b. Signature and title of certifier  ARSHPREET KAUR, MBBS.		29d. Date signed (Month, Day, Year) March 8, 2012		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARSHPREET KAUR, MBBS. Sinai Hospital of Baltimore		31. Date filed (Month, Day, Year) MAR 13 2012		
		32. Registrar's Signature 		

State
Registrar

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07168

1 - For
State
Registrar

Physician/
Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit; Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

State
Registrar

1. Decedent's Name (First, Middle, Last)							2. Date of Death Month Day Year	3. Time of Death
HECTOR TOWNSEND							MARCH 6 2012	1542 M
4a. Facility Name (if not institution, give street and number)				4b. City, Town, or Location of Death			4c. County of Death	
UNIVERSITY OF MARYLAND MEDICAL CENTER				BALTIMORE			N/A	
5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 76 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) 2-29-1936	9. Birthplace (State or Foreign Country) JAM	
Usual Residence of Decedent 215-92-0989								
10a. State MD		10b. County N/A	10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 916 N. Streeper St.					10f. Zip Code 21205	10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) N/A		16b. Kind of Business/Industry Construction Worker			16c. Date of Death 3/12/2012	
17. Father's Name (First, Middle, Last) Henry Townsend		18. Mother's Name (First, Middle, Maiden Surname) Eugenie Garvey						
19a. Informant's Name/Relationship (Type, Print) Velma Townsend - Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 916 N. Streeper St. Baltimore, MD 21205						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) ► BACI		20b. Place of Disposition (Name of cemetery, crematory or other place) Garden of Faith		Date 3/12/2012	20c. Location - City or Town, State Baltimore, MD			
21. Signature of Funeral Service Licensee ► BACI		22. Name and Address of Facility March F/H-East 1101 E. North Ave Baltimore, MD 21202						
23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a. BRAIN ANOXIA Due to (or as a consequence of):								
b. SEVERE ANEMIA Due to (or as a consequence of):								
c. GASTRO INTESTINAL HEMORRHAGE Due to (or as a consequence of):								
d. _____								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC RENAL FAILURE, CORONARY ARTERY DISEASE RECENT VENTRICULAR FIBRILLATION ARREST								23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number R133788		29d. Date signed (Month, Day, Year) MARCH 6, 2012				
29b. Signature and title of certifier ► Susan Oremba CCRP								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUSAN OREMBA 22 S GREENE STREET BALTIMORE, MARYLAND 21201								
31. Date filed (Month, Day, Year) MAR 13 2012		32. Registrar's Signature Suzanne J. Pace						

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07769

1 - For
State
RegisterPhysician/
Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/
Medical
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

Division of Vital Records, P.O. Box 68760

1. Decedent's Name (First, Middle, Last)		Florenda Thompson		2. Date of Death	Month 3 Day 8 Year 2012	3. Time of Death
4a. Facility Name (if not institution, give street and number)		University of Maryland Medical Ctr		4b. City, Town, or Location of Death		Baltimore
4c. County of Death				4d. Date of Birth		(Month, Day, Year) 9-6-1956
5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	9. Birthplace (State or Foreign Country) MD
214-64-0472		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	55 Yrs.	Months	Days	Hours Min.
Usual Residence of Decedent				10. Zip Code		10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
10a. State	10b. County	10c. City, Town or Location		21201		10g. Citizen of What Country? USA
MD		Baltimore				
10e. Street and Number		10f. Zip Code		10g. Citizen of What Country?		
833 W. Pratt Street 103		21201				
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)		14. Race - American Indian, Black, White, etc. Specify: Black
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		
15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry		
Elementary/Secondary (0-12)		College (1-4 or 5+)		Line Packages		Proctor & Gamble
17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)				
Floyd Thompson		Adell Copeland				
19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)				
Karen Pittman (Daughter)		4907 Sinclair Lane, Baltimore MD 21206				
20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date	20c. Location - City or Town, State	
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		Cedar Hill Cemetery 3/16/2012			Baltimore MD	
21. Signature of Funeral Service Licensee		22. Name and Address of Facility				
► 138 MO 553		Young's Greene Funeral Service 4905 Upper Rd. Baltimore MD 21212				
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.						
Immediate Cause (Final disease or condition resulting in death)						
a. ACUTE MYOCARDIAL INFARCTION Due to (or as a consequence of):						
b. Due to (or as a consequence of):						
c. Due to (or as a consequence of):						
d. Due to (or as a consequence of):						
Approximate Interval Between Onset and Death						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						
CONGESTIVE HEART FAILURE CHRONIC RENAL INSUFFICIENCY						
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown						
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)		28b. Time of injury	28c. Injury at work?	28d. Describe how injury occurred
		M		M	1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						
28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
29b. Signature and title of certifier ► Anna M. Matti MD		29c. License number		29d. Date signed (Month, Day, Year)		
		DS0544		MARCH 08 2012		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)						
Anna Matti, 22 S. GREENE ST. (UNIV. OF MARYLAND MED CENTER ER)						
31. Date filed (Month, Day, Year)		32. Registrar's Signature				
MAR 13 2012		Anna M. Matti				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07770

1 - For
State
RegistrarPhysician/
Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
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Physician/
Medical
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

State
Registrar

1 - For State Registrar		1. Decedent's Name (First, Middle, Last) JBN A. THOMAS				2. Date of Death Month MARCH Day 8 Year 2012		3. Time of Death 7:50 AM			
Physician/ Medical Examiner		4a. Facility Name (if not institution, give street and number) Mercy Medical Center				4b. City, Town, or Location of Death Baltimore, MD		4c. County of Death Baltimore City			
Funeral Director		5. Social Security Number 212-26-4028	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (in yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Feb. 22, 1928	9. Birthplace (State or Foreign Country) MD			
To Be Completed by Funeral Director		10a. State MD				10b. County Baltimore					
		10c. City, Town or Location Baltimore				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
		10e. Street and Number 8043 Bank Street				10f. Zip Code 21224		10g. Citizen of What Country? USA			
		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates. 1945		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White		14. Race - American Indian, Black, White, etc. Specify: White			
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Electrician		16b. Kind of Business/Industry Lockheed-Martin					
		17. Father's Name (First, Middle, Last) Aaron Thomas				18. Mother's Name (First, Middle, Maiden Surname) Stella Rice					
		19a. Informant's Name/Relationship (Type, Print) Rosie Thomas /wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8043 Bank Street Baltimore MD 21224					
		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Oak Lawn Cemetery		20b. Place of Disposition (Name of cemetery, crematory or other place) Oak Lawn Cemetery		Date 3/12/12	20c. Location - City or Town, State Baltimore MD				
		21. Signature of Funeral Service Licensee Chusina Bae				22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221					
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) METASTATIC LUNG CANCER				Approximate Interval Between Onset and Death					
		<p>a. Due to (or as a consequence of): METASTATIC LUNG CANCER</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>									
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year					
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CORONARY ARTERY DISEASE PERIPHERAL VASCULAR DISEASE DIABETES MELLITUS				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		23f. Was an autopsy performed? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
		27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number D47934				29d. Date signed (Month, Day, Year) MARCH 8, 2012			
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P. LEDATIS MD 227. ST PAUL PL. BALTIMORE MD 21202				31. Date filed (Month, Day, Year) MAR 13 2012				32. Registrar's Signature John P. Bae	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07771

1- For
State
RegistrarPhysician/
Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

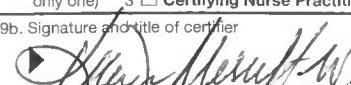
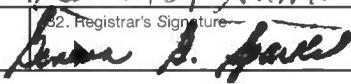
Medical Certificate: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. Decedent's Name (First, Middle, Last)		2. Date of Death				3. Time of Death				
MORRIS TISCHLER		Month MARCH 09, 2012 Day Year				3:06 A M				
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death				4c. County of Death				
7 SLADE AVENUE, #816		BALTIMORE				BALTIMORE				
5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)		If Under 1 Year		8. Date of Birth		9. Birthplace (State or Foreign Country)	
216-14-9416		<input checked="" type="checkbox"/> M <input type="checkbox"/> F	89 Yrs.		Months	Days	Hours	Min.	Month, Day, Year 03/28/1922	NJ
Usual Residence of Decedent										10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10a. State	10b. County		10c. City, Town or Location							
MD	BALTIMORE		BALTIMORE							
10e. Street and Number				10f. Zip Code			10g. Citizen of What Country?			
7 SLADE AVENUE, #816				21208			USA			
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE		
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced										
15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business/Industry					
Elementary/Secondary (0-12)		College (1-4 or 5+) 5+			ENGINEER			EDUCATION		
17. Father's Name (First, Middle, Last)				18. Mother's Name (First, Middle, Maiden Surname)						
DAVID TISCHLER				SADIE BACH						
19a. Informant's Name/Relationship (Type, Print)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)						
MARJORIE TISCHLER/WIFE				7 SLADE AVENUE, #816, BALTIMORE, MD 21208						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place)			Date	20c. Location - City or Town, State		
				BNAI ISRAEL CONGR.			03/11/2012	BALTIMORE, MD		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility				SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208		
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)				23b. Due to (or as a consequence of): <i>Alzheimer's disease</i>				Approximate Interval Between Onset and Death <i>7 months</i>		
23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year						
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DCA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier 		29c. License number D0043375				29d. Date signed (Month, Day, Year) 03/09/2012				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KAREN W. MARSHALL 6934 AVIATION PLAZA SUITE N-R GREENBELT, MD 21061										
31. Date filed (Month, Day, Year) MAR 13 2012		32. Registrar's Signature 								

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07772

1- For
State
RegistrarPhysician/
Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036
 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland
 Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 26a-f show
 any injury or other traumatic event, the Medical Examiner must be notified at
 once.

Baltimore, Maryland

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed
 within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and
 completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

Medical Certificate: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Month Day Year		3. Time of Death 7:00 A M
John Joseph Vogel		March 10, 2012		
4a. Facility Name (if not institution, give street and number) 725 W. Padonia Road		4b. City, Town, or Location of Death Cockeysville		4c. County of Death Baltimore
5. Social Security Number 220-12-6685		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months Days Hours Min. Dec 13, 1925
8. Date of Birth (Month, Day, Year) Dec 13, 1925		9. Birthplace (State or Foreign Country) Maryland		
10a. State Maryland		10b. County Baltimore		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
10e. Street and Number 725 W. Padonia Road		10f. Zip Code 21030		10g. Citizen of What Country? USA
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) n/a		16b. Kind of Business Industry Printing
17. Father's Name (First, Middle, Last) Joseph Harry Vogel		18. Mother's Name (First, Middle, Maiden Surname) Mary Ellen Roach		
19a. Informant's Name/Relationship (Type, Print) Mildred V. Vogel/Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 725 W. Padonia Road, Cockeysville, MD 21030		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Memorial Gardens		20c. Location - City or Town, State Timonium, Maryland
21. Signature of Funeral Service Licensee Bryan W. Clary		22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley Inc. 10 W. Padonia Road, Timonium, MD 21093		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (First disease or condition resulting in death) Atherosclerotic cardiovascular disease Approximate Interval Between Onset and Death years				
Immediate Cause (First disease or condition resulting in death) a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.				
23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Parkinson Disease Mental confusion				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DDA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Bryan W. Clary		
		29c. License number 030433		29d. Date signed (Month, Day, Year) Mar 12, 2012
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mildred V. Vogel 6701 N Charles Street Baltimore MD 21204				
31. Date filed (Month, Day, Year) MAR 13 2012		32. Registrar's Signature Leanne J. Parker		

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07773

1- For
State
Registrar

Physician/
Medical
Examiner

Baltimore, Maryland 21215-0036
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) Crystal Ann Whorton							2. Date of Death Month March Day 5 Year 2012	3. Time of Death 7:00 P M
4a. Facility Name (if not institution, give street and number) 859 Century St.							4b. City, Town, or Location of Death Hampstead	4c. County of Death Carroll
5. Social Security Number 214-62-0145		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 56 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) Oct 27, 1955	9. Birthplace (State or Foreign Country) IN	
Usual Residence of Decedent MD Carroll		10a. State MD 10b. County Carroll 10c. City, Town or Location Hampstead					10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 859 Century St.				10f. Zip Code 21074			10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: XX			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Executive Assistant			16b. Kind of Business/Industry Accounting		
17. Father's Name (First, Middle, Last) George Valiska				18. Mother's Name (First, Middle, Maiden Surname) Patricia Pinkston				
19a. Informant's Name/Relationship (Type, Print) Wayne Whorton Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 859 Century St., Hampstead, MD 21074				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Bayview Crematory			Date March 13, 2012	20c. Location - City or Town, State Baltimore, MD	
21. Signature of Funeral Service Licensee K. Gregory Fink MO1148				22. Name and Address of Facility Fink Funeral Home, P.A. 426 Crain Hwy S., Glen Burnie, MD 21061				

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		22. Name and Address of Facility Fink Funeral Home, P.A. 426 Crain Hwy S., Glen Burnie, MD 21061		Approximate Interval Between Onset and Death 10 months
23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred
				28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number D30929		
30. Name and address of person who completed cause of death (Item 28a) (Type, Print) Paul Celans, MD		29d. Date signed (Month, Day, Year) 3/9/2012		
31. Date filed (Month, Day, Year) MAR 13 2012		32. Registrar's Signature Susan A. Jackson		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

State of Maryland / Department of Health and Mental Hygiene

2012 07774

1- For
State
Registrar

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)							2. Date of Death	3. Time of Death		
	Helen Woods							Month March	Day 16	Year 2012	M 1548 M
Funeral Director	4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death				4c. County of Death			
	Coast Samaritan Hospital			Baltimore				N/A			
To Be Completed by Funeral Director	5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign Country)			
	212-48-2958		10 M 2 F	67 Yrs.	Months Days	Hours Min.	(Month, Day, Year) 3 17 1944	Alabama			
Usual Residence of Decedent											
10a. State	10b. County	10c. City, Town or Location							10d. Inside City Limits		
MD	N/A	Baltimore							1 Yes 2 No		
10e. Street and Number				10f. Zip Code				10g. Citizen of What Country?			
4019 The Alameda				21218				USA			
11. Marital Status											
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married		12. Was Decedent Ever in U.S. Armed Forces?			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			14. Race - American Indian, Black, White, etc.			
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			Specify: Black			
15. Decedent's Education (Specify only highest grade completed)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)				16b. Kind of Business/Industry			
Elementary/Secondary (0-12) 12th		College (1-4 or 5+) 2yrs.		Day Program Instructor				Gallagher Services			
17. Father's Name (First, Middle, Last)											
James Woods											
18. Mother's Name (First, Middle, Maiden Surname)											
Ella Pearl Payne											
19a. Informant's Name/Relationship (Type, Print)											
Michelle Woods - Sister											
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)											
2542 Arunah Ave. Baltimore, MD 21216											
20a. Method of Disposition											
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)											
20b. Place of Disposition (Name of cemetery, crematory or other place)											
King Memorial PK 3/12/2012 Randallstown, MD											
20c. Location - City or Town, State											
22. Name and Address of Facility March - East 1101 E. North Ave. Baltimore, MD 21202											
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
Immediate Cause (Final disease or condition resulting in death)											
a. Atherosclerotic cardiovascular disease											
Due to (or as a consequence of):											
b. Hypertension											
Due to (or as a consequence of):											
c. Due to (or as a consequence of):											
d. Due to (or as a consequence of):											
Approximate Interval Between Onset and Death											
year											
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last											
{											
23b. Was decedent pregnant in the past 12 months?											
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown											
23c. If yes, outcome of pregnancy											
1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)											
23d. Date of delivery											
Month Day Year											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											
cerebral vascular accident											
seizure disorder											
23e. Did tobacco use contribute to the cause of death?											
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown											
24a. Was an autopsy performed?											
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No											
24b. Were autopsy findings available prior to completion of cause of death?											
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No											
25. Was case referred to medical examiner?											
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No											
26. Place of Death (Check only one)											
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. Manner of Death											
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide											
28a. Date of Injury (Month, Day Year)											
28b. Time of Injury M											
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No											
28d. Describe how injury occurred											
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)											
28f. Location (Street and Number or Rural Route Number, City or Town, State)											
29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier											
29c. License number 1159540											
29d. Date signed (Month, Day, Year) MAR 13 2012											
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)											
Teresa Woods, physician											
31. Date filed (Month, Day, Year) MAR 13 2012											
32. Registrar's Signature											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07775

1 - For
State
Registrar

Physician/
Medical
Examiner

1. Decedent's Name (First, Middle, Last)
Earl Winthrop Williams

2. Date of Death
Month Day Year
March 08, 2012

3. Time of Death
11:40P.M.

Funeral
Director

4a. Facility Name (if not institution, give street and number)
Stella Maris Hospice

4b. City, Town, or Location of Death
Timonium

4c. County of Death
Baltimore County

5. Social Security Number
104-28-8142

6. Sex
 M F

7. Age (in yrs. last birthday)
77

If Under 1 Year
Months Days Hours Min.

Usual Residence of Decedent

10a. State
Maryland

10b. County
N/A

10c. City, Town or Location
Baltimore

10d. Inside City Limits
 Yes No

10e. Street and Number
5813 Narissus Ave.

10f. Zip Code
21215

10g. Citizen of What Country?
United States

11. Marital Status
1 Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give Year or Dates.
Air Force Peacetime

13. Was Decedent of Hispanic Origin? (Specify Yes or No)
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 Yes 2 No Specify:
African American

14. Race - American Indian, Black, White, etc.

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) **12** College (1-4 or 5+) **06**

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Systems Analyst

16b. Kind of Business/Industry
National Security Agency

17. Father's Name (First, Middle, Last)
Milton Augustine Williams

18. Mother's Name (First, Middle, Maiden Surname)
Iris Carl

19a. Informant's Name/Relationship (Type, Print)
Heather G. Williams (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
10360 Swift Stream Place Columbia, MD. 21044

20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of funeral home or cremation plan)
Evans Funeral Chapel and Cremation Services, Inc.

Date
Sunday, March 11, 2012

20c. Location - City or Town, State
(Harford County) Forest Hill, Maryland

21. Signature of Funeral Service Licensee
Jeffrey L. Gair, Sr. OFSP

21. Name and Address of Facility
Peaceful Alternatives Funeral and Cremation Center, P.A.

Lic. #M00677 2325 York Road Towson, Maryland 21093-2215

23a. Part II Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death

PROSTATE CANCER

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. _____

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 9 Unknown

23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) _____
9 Unknown

23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?
1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?
1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No

25. Was case referred to medical examiner?
1 Yes 2 No

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOD Other: 4 Nursing Home 5 Residence 6 Other (Specify) **HOSPICE**

27. Manner of Death
1 Natural 5 Pending Investigation
2 Accident 6 Could not be determined

28a. Date of injury (Month, Day, Year) 28b. Time of injury M
28c. Injury at work?
1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier
J. Morgan CRNP

29c. License number
R130272

29d. Date signed (Month, Day, Year)
3/9/2012

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

TRACIE L. MORGAN, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

31. Date filed (Month, Day, Year)
MAR 13 2012

32. Registrar Signature
Leanne A. Gair

Physician/
Medical
Examiner

To Be Completed by Physician/Medical Examiner

EARL WILLIAMS
Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

State
Registrar

2012 07776

Division of Vital Records, P.O. Box 68760, Baltimore, MD 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit permit.

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) Michael Ramon Wright	2. Date of Death Month Day Year March 5, 2012	3. Time of Death 1543 hrs				
Funeral Director		4a. Facility Name (if not institution, give street and number) Bel Air Road at Ravenwood Avenue	4b. City, Town, or Location of Death Baltimore	4c. County of Death N/A				
To Be Completed by Funeral Director		5. Social Security Number 216-08-0796	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 27 Yrs.	If Under 1 Year Months Days Hours Min. 8. Date of Birth (MM/DD/YYYY) May 15, 1984	9. Birthplace (State or Foreign Country) MD		
		10a. State MD	10b. County N/A	10c. City, Town or Location Baltimore	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
		10e. Street and Number 1512 N. Bond St		10f. Zip Code 21216		10g. Citizen of What Country? USA		
		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No specify: specify:		14. Race - American Indian, Black, White, etc. Black
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Warehouse Worker		16b. Kind of Business/Industry Second Chance		
		17. Father's Name (First, Middle, Last) Raymond L. Wright Sr.		18. Mother's Name (First, Middle, Maiden Surname) Bernadette Strawder				
		19a. Informant's Name/Relationship (Type, Print) Bernadette Strawder		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1512 N Bond St, Baltimore, MD				
		20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other Specify: Capawn		20b. Place of Disposition (Name of cemetery, crematory or other place) Capawn		Date 3/10/2012	20c. Location - City or Town, State Baltimore, MD	
		21. Signature of Funeral Service Licensee Alan R. Strawder Sr.		22. Name and Address of Facility Howell Funeral Home 3331 Belknap Ln, Baltimore, MD				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Multiple Injuries Due to (or as a consequence of):				Approximate Interval Between Onset and Death				
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last UNPENDED		b. Due to (or as a consequence of):						
		c. Due to (or as a consequence of):						
		d. Due to (or as a consequence of):						
<input type="checkbox"/> UNPENDED		<input type="checkbox"/> AMENDED						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
				24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
				24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26 Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene						
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month Day Year) Mar 5, 2012		28b. Time of Injury 1535 hrs		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how injury occurred Driver auto auto collision		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Major Road / Highway		28f. Location (Street and Number or Rural Route Number, City or Town, State) Bel Air Road at Ravenwood Avenue, Baltimore, MD				
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Ling Li, MD		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) March 6, 2012				
30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223								
31. Date filed (Month, Day, Year) MAR 13 2012		32. Registrar's Signature J. J. [Signature]						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#14per FH, G925, 3/13/2012 WS

State of Maryland / Department of Health and Mental Hygiene

1 - For
State
Registrar

Certificate of Death

Reg. No. 2012 07777

Physician/
Medical
Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death			3. Time of Death
<i>YEON CHONG WHANG</i>	Month	Day	Year	1701 M
4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death			4c. County of Death
<i>SHADY GLOVE ADVENTIST HOSP</i>	<i>ROCKVILLE</i>			<i>MONTGOMERY</i>

Funeral
Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign Country)
<i>214-80-3294</i>	<input checked="" type="checkbox"/> M <input type="checkbox"/> F	72 Yrs.	Months	Days	(Month, Day, Year)	<i>07-07-1959 KOREA</i>
Usual Residence of Decedent						

To Be Completed by Funeral Director

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
<i>MD</i>	<i>MONTGOMERY</i>	<i>ROCKVILLE</i>	<input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
<i>10603 TUPPENCE COURT</i>	<i>20850</i>	<i>USA</i>

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	Asian Specify: <i>BLACK</i>

15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
<i>Elementary/Secondary (0-12)</i>	<i>CHEF</i>	<i>Food SERVICE</i>
College (1-4 or 5+)		

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
<i>UNK</i>	<i>UNK</i>

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>BOK HUI WHANG</i>	<i>10603 TUPPENCE CT, ROCKVILLE, MD 20850</i>

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	<i>Northeast Mort PK</i>	<i>3-10-12</i>	<i>ANNAPOLIS MD</i>

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
<i>[Signature]</i>	<i>Holiday Inn Hotel 10220 GOLF RD, BETHESDA MD 20854</i>

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	Approximate Interval Between Onset and Death
a. <i>cardio pulmonary arrest</i> Due to (or as a consequence of):	
b. <i>Buckit's Lymphoma</i> Due to (or as a consequence of):	
c. _____ Due to (or as a consequence of):	
d. _____	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
--	---	---

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
--	--

24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
---	---

25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)
---	---

27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
--	--	---------------------	--	-----------------------------------

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
--	--

29a. Certifier (Check only one)	1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
------------------------------------	--

29b. Signature and title of certifier <i>[Signature] M.D.</i>	29c. License number <i>D0065505</i>	29d. Date signed (Month, Day, Year) <i>March 7, 2012</i>
--	--	---

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
--

31. Date filed (Month, Day, Year) <i>MAR 13 2012</i>	32. Registrar's Signature <i>[Signature]</i>
---	---

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

Whang, Yeon 3/6/2012 07777

Important: If Item 27 is marked other than "natural", or items 2a or 2b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

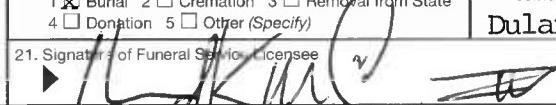
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07778

1- For
State
RegistrarPhysician/
Medical
Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death				3. Time of Death		
Charles Harry Wollenweber Sr.		Month March 9, 2012 Day Year				11:25 PM		
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death				4c. County of Death		
Upper Chesapeake Medical Center		Bel Air				Harford		
5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day, Year)		9. Birthplace (State or Foreign Country)
220-18-3472		1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	84 Yrs.	Months	Days	Hours	Min.	June 16, 1927 Maryland
Usual Residence of Decedent								10d. Inside City Limits
10a. State		10b. County		10c. City, Town or Location				10d. Inside City Limits
Maryland		Harford		Edgewood				1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
10e. Street and Number		10f. Zip Code				10g. Citizen of What Country?		
319 Kennard Avenue		21040				USA		
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			14. Race - American Indian, Black, White, etc.	
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates.		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			Specify: White	
15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)				16b. Kind of Business/Industry		
Elementary/Secondary (0-12) 10		College (1-4 or 5+) Owner/Operator				Trucking Company		
17. Father's Name (First, Middle, Last)					18. Mother's Name (First, Middle, Maiden Surname)			
Charles (nmn) Wollenweber					Thelma Idalis Davis			
19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)						
Virginia Wollenweber / Wife		319 Kennard Ave., Edgewood, Maryland 21040						
20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date		20c. Location - City or Town, State		
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		Dulaney Valley Mem. Gdn 3-13-12				Timonium, Maryland		
21. Signature of Funeral Service Licensee		22. Name and Address of Facility						
		McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009						
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
Approximate Interval Between Onset and Death								
Immediate Cause (Final disease or condition resulting in death)								
a. Due to (or as a consequence of):  Probable Abdominal Aortic Aneurysm Rupture 5 minutes								
b. Due to (or as a consequence of):								
c. Due to (or as a consequence of):								
d. _____								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> D.O.A. Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier  nd.		29c. License number D0035012				29d. Date signed (Month, Day, Year) March 12, 2012		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)								
J. Kevin Lynch, M.D. 615 W. MacPhail Rd., Suite 212 Bel Air, MD 21014								
31. Date filed (Month, Day, Year) MAR 13 2012		32. Registrar's Signature 						

MD 800532410
Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Wollenweber, Charles Harry Sr.
Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use at the burial/transit.

Medical Certificate: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07779

1 - For
State
Registrar

Physician/
Medical
Examiner

1. Decedent's Name (First, Middle, Last)		Barbara Walker		2. Date of Death			3. Time of Death	
				Month	Day	Year	M	
4a. Facility Name (if not institution, give street and number)		The Johns Hopkins Hospital		4b. City, Town, or Location of Death		4c. County of Death		
				Baltimore City		N/A		
5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign Country)	
213-32-1080		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	76 Yrs.	Months	Days	Hours	Min. 9/10/35 NC	
Usual Residence of Decedent		10a. State MD		10b. County N/A		10c. City/Town or Location Baltimore		10d. Inside City Limits
								1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
10e. Street and Number		10f. Zip Code		10g. Citizen of What Country?				
1512 Abbotston St.		21218		USA				
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)		14. Race - American Indian, Black, White, etc.		
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		African Amer.		
15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry				
Elementary/Secondary (0-12) 12		College (1-4 or 5+) Supervisor		Housekeeping				
17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)						
Herbert Barfield		unk						
19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)						
Daughter Beverly Barfield Henson		1512 Abbotston St., Balt., MD 21218						
20a. Method of Disposition		20b. Place of Disposition (Name of Cemetery, Crematory or other place)		Date	20c. Location - City or Town, State			
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		King Memorial Pk		3/17/12	Balt. Cty, MD			
21. Signature of Funeral Service Licensee		22. Name and Address of Facility		Hari P Close F Sys PA				
		5126 Belair Rd, Balt., MD 21206-5105						
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. If yes, outcome of pregnancy		23d. Date of delivery		Approximate Interval Between Onset and Death		
Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown		Month Day Year				
a. <u>Sepsis</u> Due to (or as a consequence of):		b. <u>right upper lobe pneumonia</u> Due to (or as a consequence of):		c. <u>COPD (chronic obstructive pulmonary disease)</u> Due to (or as a consequence of):		d. _____		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy		23d. Date of delivery				
23e. Did tobacco use contribute to the cause of death?		23f. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23g. 23e. Did tobacco use contribute to the cause of death?				
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> D.O.A		Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		23e. Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
27. Manner of Death		28a. Date of injury (Month, Day, Year)		28b. Time of injury	28c. Injury at work?	28d. Describe how injury occurred		
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		M	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one)		29b. Signature and title of certifier		29c. License number		29d. Date signed (Month, Day, Year)		
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				PES-000		March 7, 2012		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		31. Date filed (Month, Day, Year)		32. Registrar's Signature				
Jennifer Bruno, MD		MAR 13 2012				600 N Wolfe St, Baltimore MD, 21287		

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

within 24 hours after death.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

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State
Registrar

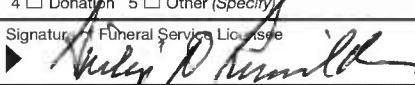
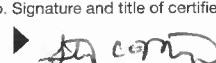
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07780

1 - For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Sylvie Noelle Anoma				2. Date of Death Month February Day 10 Year 2012	3. Time of Death 2:30 AM			
	4a. Facility Name (If not institution, give street and number) 14725 Wexhall Drive		4b. City, Town, or Location of Death Burtonsville		4c. County of Death Montgomery				
Funeral Director	5. Social Security Number 214-71-3403	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 42 Yrs.	If Under 1 Year Months 0	If Under 24 Hrs. Days 0	8. Date of Birth Month 1901 Day 19 Year 1970	9. Birthplace (State or Foreign Country) Ivory Coast		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State MD 10b. County Montgomery 10c. City, Town or Location Burtonsville						10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 14725 Wexhall Drive		10f. Zip Code 20866		10g. Citizen of What Country? Ivory Coast				
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) Security Officer		16b. Kind of Business Industry Security				
	17. Father's Name (First, Middle, Last) Seka Anoma				18. Mother's Name (First, Middle, Maiden Surname) Chaye Seline Don				
	19a. Informant's Name/Relationship (Type, Print) Amie Adompo/Cousin		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 200 Blanca Court Frederick, Md. 21702						
Physician/ Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Montezo Cemetery		Date 3/18/2012	20c. Location - City or Town, State Alepe, Ivory Coast			
	21. Signature of Funeral Service Licensee 		21b. Name and Address of Funeral Service Licensee PATRICK PIRNALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd. Silver Spring, Md 20910						
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Human Immunodeficiency Virus-Related Complications							Approximate Interval Between Onset and Death 2008 (4 Years)	
	a. Due to (or as a consequence of): Pulmonary Hemorrhage							1 week	
	b. Due to (or as a consequence of):								
	c. Due to (or as a consequence of):								
	d. Due to (or as a consequence of):								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Disseminated Tuberculosis (resolved) Toxoplasmosis							23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred			
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
	29b. Signature and title of certifier 		29c. License number 0101052463 (VA)		29d. Date signed (Month, Day, Year) 02/12/2012				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen A. McGuire		10 Center Drive, Bethesda, Maryland 20892						
	31. Date filed (Month, Day, Year) FEB 27 2012		32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial slip.

Medical Certificate: To Be Completed by Physician/Medical Examiner

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- FORM #20b per FH
State MARYLAND DEPT 2/24/2012 cert
Registrar

Certificate of Death

Reg. No.

2012 07781

3. Time of Death

February 22, 2012 7:40 P.M.

Baltimore, Maryland 21215-0036
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/
Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Physician/ Medical Examiner	Mary Alice Bare Auld	2. Date of Death Month Day Year	3. Time of Death		
Funeral Director	Future Care	Arnold	Anne Arundel		
	4. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death		
	5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	8. Date of Birth Month Day Year	9. Birthplace (State or Foreign Country)
	220-03-1704	1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	93 Yrs.	12/27/1918	MD
	Usual Residence of Decedent			10d. Inside City Limits 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10a. State	10b. County	10c. City, Town or Location	Stevensville	
	MD	Queen Anne			
	10e. Street and Number	10f. Zip Code		10g. Citizen of What Country?	
	205 Beachside DR.	21666		USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Homemaker	16b. Kind of Business Industry Own Home		
	17. Father's Name (First, Middle, Last) James W. Bare	18. Mother's Name (First, Middle, Maiden Surname) Mary L. Harper			
	19a. Informant's Name/Relationship (Type, Print) Annette Kassa	daughter	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 205 Beachside DR. Stevensville, MD 21666		
	20a. Method of Disposition 1 <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) Atlantic Crematory	20c. Location - City or Town, State Glen Burnie, MD		
	21. Signature of Funeral Service Licensee ► Cynthia Reinbold	22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401			

Physician/
Medical
Examiner

To Be Completed by Physician/Medical Examiner

23a. Part 1: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	Approximate Interval Between Onset and Death			
a. Due to (or as a consequence of): Cerebrovascular disease				
b. Due to (or as a consequence of):				
c. Due to (or as a consequence of):				
d. Due to (or as a consequence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. dementia coronary artery disease	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA	Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined	28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	29b. Signature and title of certifier ► Mohit Negi, M.D.			
	29c. License number DS7531	29d. Date signed (Month, Day, Year) February 23, 2012		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mohit Negi 8601 Veterans Hwy, Millersville, MD 21108				
31. Date filed (Month, Day, Year) FEB 24 2012	32. Registrar's Signature Anna P. Parker			

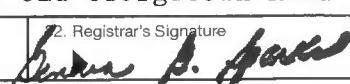
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07782

1 - For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Dennis Brown					2. Date of Death Month February Day 23 , Year 2012	3. Time of Death 5:52 A M		
	4a. Facility Name (if not institution, give street and number) Suburban Hospital			4b. City, Town, or Location of Death Bethesda		4c. County of Death Montgomery			
Funeral Director	5. Social Security Number 142-30-8690	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (in yrs. last birthday) 80 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 05/17/1931	9. Birthplace (State or Foreign Country) New Jersey		
To Be Completed by Funeral Director	10a. State MD		10b. County Montgomery	10c. City, Town or Location Rockville			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number 6111 Montrose Road, #417			10f. Zip Code 20852		10g. Citizen of What Country? United States			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates 1953-55	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White	14. Race - American Indian, Black, White, etc. White					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 4	16b. Kind of Business/Industry Business Owner		16c. Kind of Business/Industry Clothing			
	17. Father's Name (First, Middle, Last) Frank Brown			18. Mother's Name (First, Middle, Maiden Surname) Celia Roth					
	19a. Informant's Name/Relationship (Type, Print) Kenneth Nolan Brown-Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 502 Calvin Lane Rockville, MD 20851						
Physician/ Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) M01163		20b. Place of Disposition (Name of cemetery, crematory or other place) National Crematory	Date 02/25/2012	20c. Location - City or Town, State Falls Church, VA				
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Edward Sage Funeral Direction, Inc. 1091 Rockville Pike Rockville, MD 20852						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Hypoxic Respiratory Failure						Approximate Interval Between Onset and Death 11 Days		
	b. Due to (or as a consequence of): Bilateral Pneumonia								
	c. Due to (or as a consequence of):								
	d. Due to (or as a consequence of):								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Urinary Tract Infection						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DODA		Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred			
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
	29b. Signature and title of certifier 		29c. License number D72726			29d. Date signed (Month, Day, Year) February 23, 2012			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lori Pihi, MD 8600 Old Georgetown Road Bethesda, MD 20817								
State Registrar	31. Date filed (Month, Day, Year) FEB 27 2012		32. Registrar's Signature 						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07783

1 - For
State
RegistrarPhysician/
Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last) Harry Bokow			2. Date of Death Month February Day 23 , Year 2012		3. Time of Death 7:50 AM
4a. Facility Name (if not institution, give street and number) Holy Cross Hospital			4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery
5. Social Security Number 118-18-6036		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (in yrs. last birthday) 86 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 10/28/1925
Usual Residence of Decedent 10a. State MD			10b. County Montgomery	10c. City, Town or Location Silver Spring	
10e. Street and Number 903 Malta Lane			10f. Zip Code 20901		10g. Citizen of What Country? United States
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates. 1943-1946		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Civil Engineer		16b. Kind of Business/Industry Federal Government
17. Father's Name (First, Middle, Last) Sam Bokow			18. Mother's Name (First, Middle, Maiden Surname) Clara Danovska		
19a. Informant's Name/Relationship (Type, Print) Jerry Bokow-Son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 903 Malta Lane Silver Spring, MD 20901		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Judean Mem Grdns		Date 02/26/2012
21. Signature of Funeral Service Licensee Mallie Bokow			22. Name and Address of Facility Chapels, Inc. 1170 Rockville Pike Rockville, MD 20852		

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transcript.

Medical Certificate: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Aspiration Pneumonia		Approximate Interval Between Onset and Death
<p>a. Due to (or as a consequence of): Gastric Volvulus</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. _____</p>				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29b. Signature and title of certifier Yodit Negusse.		29c. License number D89288		29d. Date signed (Month, Day, Year) February 23, 2012
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Yodit Negusse, MD 1500 Forest Glen Road Silver Spring, MD 20910				
31. Date filed (Month, Day, Year) FEB 27 2012		32. Registrar's Signature Leanne A. Jacobs		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

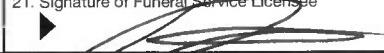
Reg. No. 2012 07784

1- For
State
Registration

AMEND #16a/Dec 11, 2/29/12, BM, MCO

Physician/
Medical
Examiner1. Decedent's Name (First, Middle, Last)
Sondra Dosik Bender2. Date of Death
Month Day Year
February 22, 2012
3. Time of Death
1:40 P MFuneral
Director4a. Facility Name (if not institution, give street and number)
7400 Radnor Road4b. City, Town, or Location of Death
Bethesda4c. County of Death
Montgomery5. Social Security Number
577-42-9241 6. Sex
1 M 2 F 7. Age (In yrs. last birthday)
78 Yrs. If Under 1 Year
Months Days Hours Min.
8. Date of Birth
(Month Day Year)
09/01/1933 9. Birthplace (State or Foreign
Country)
New York

Usual Residence of Decedent

10a. State
MD 10b. County
Montgomery 10c. City, Town or Location
Bethesda 10d. Inside City Limits
1 Yes 2 No10e. Street and Number
7400 Radnor Road 10f. Zip Code
20817 10g. Citizen of What Country?
United States11. Marital Status
1 Never Married 2 Married
3 Widowed 4 Divorced 12. Was Decedent Ever in U.S.
Armed Forces?
1 Yes 2 No
If Yes, Give
Year or Dates.
13. Was Decedent of Hispanic Origin? (Specify Yes or No)
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 Yes 2 No Specify:
14. Race - American Indian,
Black, White, etc.
Specify: **White**15. Decedent's Education
(Specify only highest grade completed)
Elementary/Seconday (0-12) **12** College (1-4 or 5+) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
Philanthropist 16b. Kind of Business Industry
Philanthropy
Philanthropy17. Father's Name (First, Middle, Last)
Abraham Dosik 18. Mother's Name (First, Middle, Maiden Surname)
Ida Blum Dosik19a. Informant's Name/Relationship (Type, Print)
Howard M. Bender-Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7400 Radnor Road Bethesda, MD 2081720a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)
King David Mem Gdns 20b. Place of Disposition (Name of
cemetery, crematory or other place)
King David Mem Gdns Date
2/24/2012 20c. Location - City or Town, State
Falls Church, Virginia21. Signature of Funeral Service Licensee
 M01163 22. Name and Address of Facility
**Panzansky-Goldberg Memorial
Chapels, Inc.** 170 Rockville Pike
Rockville, MD 2085223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
Uremia
Sequentially list conditions, if any, leading to immediate cause. Enter Uremia as Cause (Disease or injury that initiated events resulting in death) Last
a. Due to (or as a consequence of):
Renal Failure
b. Due to (or as a consequence of):
Metastatic Carcinoma Of The Uterus
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):IF FEMALE:
23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No
g Unknown 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) _____
9 Unknown 23d. Date of delivery
Month Day YearPart II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
23e. Did tobacco use contribute to the cause of death?
1 Yes 2 No 3 Probably 4 Unknown24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No25. Was case referred to medical examiner?
1 Yes 2 No Hospital: 26. Place of Death (Check only one)
1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)27. Manner of Death
1 Natural 5 Pending Investigation
2 Accident 6 Could not be determined
3 Suicide 4 Homicide 28a. Date of injury
(Month, Day, Year) 28b. Time of injury
M 28c. Injury at work?
1 Yes 2 No 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.29b. Signature and title of certifier
 29c. License number
D35579 29d. Date signed (Month, Day, Year)
02/22/201230. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Susan J. Miller, MD 8218 Wisconsin Avenue, Suite 305 Bethesda, MD 2081431. Date filed (Month, Day, Year)
FEB 27 2012 32. Registrar's Signature


Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial transit slip.

Medical Certificate: To Be Completed by Physician/Medical Examiner

24

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07785

1- For State Registrar AMEND#25 per MD 3/1/12; BMW, MoCo

Physician/
Medical
Examiner

1. Decedent's Name (First, Middle, Last) CARL WESLEY BELL		2. Date of Death Month Day Year 2/20/2012		3. Time of Death 0208 M
4a. Facility Name (if not institution, give street and number) Shady Grove Hospital		4b. City, Town, or Location of Death Rockville, MD		4c. County of Death Montgomery
5. Social Security Number 256-48-2618		6. Sex 1 X M 2 □ F	7. Age (In yrs. last birthday) 76 Yrs.	If Under 1 Year Months Days Hours Min. If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1/7/1936
Usual Residence of Decedent MD Montgomery		9. Birthplace (State or Foreign Country) MD		
10a. State MD		10b. County Montgomery	10c. City, Town or Location Damascus	
10e. Street and Number 25513 Ridge Road		10f. Zip Code 20872		10g. Citizen of What Country? USA
11. Marital Status 1 X Never Married 2 □ Married 3 □ Widowed 4 □ Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates 1953-1966	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 X No Specify:	14. Race - American Indian, Black, White, etc. Black
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 2yrs	16b. Kind of Business/Industry Rockville Truck Driver- Crushed Stone	Transportation
17. Father's Name (First, Middle, Last) Louis Bell		18. Mother's Name (First, Middle, Maiden Surname) Edna Hood		

19a. Informant's Name/Relationship (Type, Print) Peggy Chatmon/companion		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25513 Ridge Road, Damascus, MD 20872		
20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cem.	Date 2/27/2012	20c. Location - City or Town, State Silver Spring, MD
21. Signature of Funeral Service Licensee George R. Snowden		22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St., Rockville, MD 20850		

Physician/
Medical
Examiner

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death		
<p>a. Due to (or as a consequence of): <i>End stage renal disease</i></p> <p>b. Due to (or as a consequence of): <i>Hypertension</i></p> <p>c. Due to (or as a consequence of): <i>Diseases Melts</i></p> <p>d. Due to (or as a consequence of): <i>Dementia</i></p>				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		23c. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (Specify) 9 □ Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 □ Probably 4 X Unknown
25. Was case referred to medical examiner? 1 □ Yes 2 X No		26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)		24a. Was an autopsy performed? 1 □ Yes 2 X No
27. Manner of Death 1 X Natural 5 □ Pending Investigation 2 □ Accident 6 □ Could not be determined 3 □ Suicide 4 □ Homicide		28a. Date of injury (Month, Day, Year) 1 X	28b. Time of injury M	28c. Injury at work? 1 □ Yes 2 □ No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) At home		28d. Describe how injury occurred
29a. Certifier (Check only one) 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 □ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		28f. Location (Street and Number or Rural Route Number, City or Town, State) City or Town, State		
29b. Signature and title of Certifier Ahmed Heshmat, MD		29c. License number 00057574		29d. Date signed (Month, Day, Year) 2/20/12
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ahmed Heshmat, MD 10301 Georgia Ave. Silver Spring, MD 20902				
31. Date filed (Month, Day, Year) FEB 27 2012		32. Registrar's Signature Leanne P. Jacobs		

Division of Vital Records, P.O. Box 68760

To the Physician or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07786

1 - For State Registrar		1. Decedent's Name (First, Middle, Last) <i>Lajos Bela Balla</i>						2. Date of Death Month <u>02</u> Day <u>22</u> Year <u>2012</u>			3. Time of Death <u>2140</u> M		
Physician/ Medical Examiner		4a. Facility Name (if not institution, give street and number) <i>University of Maryland Medical Center</i>						4b. City, Town, or Location of Death <i>Baltimore, MD</i>			4c. County of Death		
Funeral Director		5. Social Security Number <u>041-30-9258</u>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <u>83</u> Yrs.	If Under 1 Year Months <u></u> Days <u></u>		If Under 24 Hrs. Hours <u></u> Min. <u></u>		8. Date of Birth (Month, Day, Year) <u>10/17/1928</u>		9. Birthplace (State or Foreign Country) <u>Hungary</u>	
To Be Completed by Funeral Director		10a. State <u>DC</u>	10b. County	10c. City, Town or Location <i>Washington</i>								10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner		10e. Street and Number <i>4835 Sedgwick Street NW</i>						10f. Zip Code <u>20016</u>			10g. Citizen of What Country? <u>United States</u>		
Medical Certificate: To Be Completed by Physician/Medical Examiner		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <u>1957-</u> If Yes, Give Year or Dates <u>1958</u>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify <u>White</u>			
Medical Certificate: To Be Completed by Physician/Medical Examiner		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>5+</u> College (1-4 or 5+) <u></u>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Medical Doctor</u>				16b. Kind of Business/Industry <u>Medicine</u>				
Medical Certificate: To Be Completed by Physician/Medical Examiner		17. Father's Name (First, Middle, Last) <i>Lajos Balla</i>						18. Mother's Name (First, Middle, Maiden Surname) <i>Margit Trux</i>					
Medical Certificate: To Be Completed by Physician/Medical Examiner		19a. Informant's Name/Relationship (Type, Print) <i>Josephine Balla / Spouse</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>4835 Sedgwick St. NW Washington, DC 20016</i>							
Medical Certificate: To Be Completed by Physician/Medical Examiner		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>National Crematory</i>				20b. Place of Disposition (Name of cemetery, crematory or other place)		Date <u>03/03/2012</u>		20c. Location - City or Town, State <u>Falls Church, VA</u>			
Medical Certificate: To Be Completed by Physician/Medical Examiner		21. Signature of Funeral Service Licensee <i>W. Andy Meany</i>				22. Name and Address of Facility <i>Joseph Gawler's Sons Inc.</i> <i>5130 Wisconsin Ave. NW Washington, DC 20016</i>							
Medical Certificate: To Be Completed by Physician/Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last											
Medical Certificate: To Be Completed by Physician/Medical Examiner		23b. Due to (or as a consequence of): <i>idiopathic pulmonary fibrosis</i>											
Medical Certificate: To Be Completed by Physician/Medical Examiner		23c. Due to (or as a consequence of):											
Medical Certificate: To Be Completed by Physician/Medical Examiner		23d. Due to (or as a consequence of):											
Medical Certificate: To Be Completed by Physician/Medical Examiner		23e. Approximate Interval Between Onset and Death											
Medical Certificate: To Be Completed by Physician/Medical Examiner		23f. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown											
Medical Certificate: To Be Completed by Physician/Medical Examiner		23g. 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown											
Medical Certificate: To Be Completed by Physician/Medical Examiner		23h. 23d. Date of delivery Month <u></u> Day <u></u> Year <u></u>											
Medical Certificate: To Be Completed by Physician/Medical Examiner		23i. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											
Medical Certificate: To Be Completed by Physician/Medical Examiner		23j. 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown											
Medical Certificate: To Be Completed by Physician/Medical Examiner		23k. 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
Medical Certificate: To Be Completed by Physician/Medical Examiner		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
Medical Certificate: To Be Completed by Physician/Medical Examiner		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____											
Medical Certificate: To Be Completed by Physician/Medical Examiner		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Determined <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined											
Medical Certificate: To Be Completed by Physician/Medical Examiner		28a. Date of injury (Month, Day, Year) <u></u> 28b. Time of injury M 28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No											
Medical Certificate: To Be Completed by Physician/Medical Examiner		28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) _____											
Medical Certificate: To Be Completed by Physician/Medical Examiner		28f. Location (Street and Number or Rural Route Number, City or Town, State) _____											
Medical Certificate: To Be Completed by Physician/Medical Examiner		29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
Medical Certificate: To Be Completed by Physician/Medical Examiner		29b. Signature and title of certifier <i>Ny-Ying Lam</i>											
Medical Certificate: To Be Completed by Physician/Medical Examiner		29c. License number <u>P27331</u>											
Medical Certificate: To Be Completed by Physician/Medical Examiner		29d. Date signed (Month, Day, Year) <u>02/22/2012</u>											
Medical Certificate: To Be Completed by Physician/Medical Examiner		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Ny-Ying Lam 22 S. Greene St Baltimore, MD 21201</i>											
Medical Certificate: To Be Completed by Physician/Medical Examiner		31. Date filed (Month, Day, Year) <u>FEB 27 2012</u>			32. Registrar's Signature <i>Sandra B. Parker</i>								

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit slip.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07787

1- For
State
Registrar

Physician/
Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death
John Louis Borzi		Feb. 25, 2012		3:00 a ^M
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
Calvert County Nursing Center		Prince Frederick		Calvert
5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 91 Yrs.	If Under 1 Year Months Days Hours Min.
051-14-8756				
8. Date of Birth (Month, Day, Year) 11/24/1920		9. Birthplace (State or Foreign Country) DC		
Usual Residence of Decedent		10a. State MD		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10b. County Calvert		10c. City, Town or Location Prince Frederick		
10e. Street and Number 125 Allnutt Court #209		10f. Zip Code 20678		10g. Citizen of What Country? USA
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates. WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
				14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Bricklayer		16b. Kind of Business Industry Construction
17. Father's Name (First, Middle, Last) Anthony Borzi		18. Mother's Name (First, Middle, Maiden Surname) Zena Mary Sambataro		
19a. Informant's Name/Relationship (Type, Print) Mary Faircloth/ Niece		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 621 Walton Rd., Huntingtown, MD 20639		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Ft. Lincoln Cem.		Date 3/1/12
20c. Location - City or Town, State Brentwood, MD				
21. Signature of Funeral Service Licensee ► C. Woot		22. Name and Address of Facility Raymond-Wood F.H., P.A. PO Box 430, Dunkirk, MD 20754		
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death
		a. Atherosclerotic Cardiovascular disease Due to (or as a consequence of):		
		b. Hypertensive Cardiovascular disease Due to (or as a consequence of):		
		c. Due to (or as a consequence of):		
		d. Due to (or as a consequence of):		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> D.O.A Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M
		28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number D-50653		29d. Date signed (Month, Day, Year) 2-27-2012
29b. Signature and title of certifier ► Leyon - C. Surono				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Deale M.D. 20751		31. Date filed (Month, Day, Year) FEB 27 2012		32. Registrar's Signature Leyon B. Surono

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07788

1- For
State
Registrar

Physician/
Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
Charles Stanley Burch Sr.			February 22, 2012 4:26 p.m.	
4a. Facility Name (if not institution, give street and number)			4b. City, Town, or Location of Death	
St. Mary's Hospital			Leonardtown	
4c. County of Death			St. Mary's	
5. Social Security Number			6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 90 Yrs.
578-12-1043			If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
			8. Date of Birth (Month, Day, Year) 03/26/1921	9. Birthplace (State or Foreign Country) Washington, DC
Usual Residence of Decedent			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10a. State Maryland		10b. County St. Mary's	10c. City, Town or Location St. Inigoes	
10e. Street and Number 47918 Waterview Drive			10f. Zip Code 20684	10g. Citizen of What Country? United States
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) /		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Owner	16b. Kind of Business Industry Auto Supply Store	
17. Father's Name (First, Middle, Last) Stanislaus Kostka Burch			18. Mother's Name (First, Middle, Maiden Surname) Ethel Carrico	
19a. Informant's Name/Relationship (Type, Print) Charles S. Burch, Jr./Son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 47918 Waterview Drive, St. Inigoes, MD 20684	
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Brinsfield-Echols Cre	Date 02/25/2012	20c. Location - City or Town, State Charlotte Hall, MD
21. Signature of Funeral Service Licensee Edward N. Brinsfield, Jr. M00052			22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 20650	
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Bladder cancer				
Approximate Interval Between Onset and Death 20 yrs				
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Congestive heart failure				
c. Due to (or as a consequence of): d. Due to (or as a consequence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown		
23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Radical hysterectomy & med loop ca 2/15/2012				
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Impatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No
28d. Describe how injury occurred				
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. Signature and title of certifier Krishna P. Jayaraman, M.D.				
29c. License number D 20177				
29d. Date signed (Month, Day, Year) 02/23/2012				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Krishna P. Jayaraman, M.D. 25500 Point Lookout Road, Leonardtown, MD 20650				
31. Date filed (Month, Day, Year) FEB 27 2012				
32. Registrar's Signature Jesse A. Jones				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07789

1 - For
State
Registrar

Physician/
Medical
Examiner

Baltimore, Maryland 21215-0036
Permit: Page 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
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within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completed filled in by the funeral director, page 2 should be detached for use as the burial/transit

Division of Vital Records, P.O. Box 68760

State
Registrar

Medical Certificate: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death
Clare Virginia Baines		February 22, 2012		12:55 PM
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
3224 Harness Creek Road		Annapolis		Anne Arundel
5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 89 Yrs.	If Under 1 Year Months Days Hours Min. 11/4/1922
337-14-7889				8. Date of Birth (Month, Day, Year)
Usual Residence of Decedent		10c. City, Town or Location		9. Birthplace (State or Foreign Country) Illinois
10a. State Delaware	10b. County Sussex	Bethany Beach		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number 715 Deer Leap		10f. Zip Code 19930		10g. Citizen of What Country? USA
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Homemaker	16b. Kind of Business Industry Home		
17. Father's Name (First, Middle, Last) Joseph Smutnak		18. Mother's Name (First, Middle, Maiden Surname) Veronica unknown		
19a. Informant's Name/Relationship (Type, Print) Thomas P. Baines/ Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3224 Harness Creek Rd., Annapolis, MD 21403		
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Kalas Crematory	Date 2/24/12	20c. Location - City or Town, State Edgewater, MD
21. Signature of Funeral Service Licensee ► [Signature]		22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037		
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) { a. Due to (or as a consequence of): Rectal Adenocarcinoma b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death				
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Son's Home		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No
		28d. Describe how injury occurred		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier ► [Signature] DR RAVIN GARG		
		29c. License number D0064852		29d. Date signed (Month, Day, Year) 02/22/2012
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr RAVIN GARG ONCOLOGIST ANNAPOULS ONCOLOGY				
31. Date filed (Month, Day, Year) FEB 24 2012		32. Registrar's Signature Renew A. Parker		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07790

1- For State Registrar

**Physician/
Medical Examiner**

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death 1818 hrs
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John Boniface, III

February 21, 2012

Newburg
Charles**Funeral Director**

4a. Facility Name (if not institution, give street and number) Harry W. Nice Memorial Bridge	4b. City, Town, or Location of Death Newburg	4c. County of Death Charles
---	---	--------------------------------

5. Social Security Number 230-25-6332	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 46 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (MM/DD/YYYY) Jan. 13, 1966	9. Birthplace (State or Foreign Country) Florida
--	--	---	---	--	---

Usual Residence of Decedent

10a. State VA	10b. County King George	10c. City, Town or Location King George	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
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10e. Street and Number 10161 LANDFALL LANE	10f. Zip Code 22485	10g. Citizen of What Country? U.S.A.
---	------------------------	---

11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify:	14. Race - American Indian, Black, White, etc. Specify: White
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15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)	16b. Kind of Business/Industry 4 BLdg. Official
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17. Father's Name (First, Middle, Last) John Boniface, Jr.	18. Mother's Name (First, Middle, Maiden Surname) Carole Sue Higginbotham
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19a. Informant's Name/Relationship (Type, Print) John Boniface, Jr.	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10161 Landfall Ln. King George, VA 22485
--	---

20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State	20b. Place of Disposition (Name of cemetery, crematory or other place) Mercer Crematory	Date	20c. Location - City or Town, State Fredericksburg, VA
---	--	------	---

21. Signature of Funeral Service Licensee Em. Taliason	22. Name and Address of Facility CCO395 Nash + Slow F.H. King George, VA.
---	--

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	Approximate Interval Between Onset and Death
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a. Multiple Injuries Due to (or as a consequence of):	
--	--

b.	Due to (or as a consequence of):
----	----------------------------------

c.	Due to (or as a consequence of):
----	----------------------------------

d.	
----	--

<input type="checkbox"/> UNPENDED	<input type="checkbox"/> AMENDED
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IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
--	---	---

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
--	--

	24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
--	---	--

25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA	26. Place of Death (Check only one) Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene
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27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input checked="" type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day, Year) Feb 21, 2012	28b. Time of Injury 1750 hrs	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	28d. Describe how injury occurred Subject jumped from a bridge
--	--	---------------------------------	---	---

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Bridge	28f. Location (Street and Number or Rural Route Number, City or Town, State) Harry W. Nice Memorial Bridge, Newburg, MD
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29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) February 22, 2012
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29b. Signature and title of certifier Pamela E. Southall, MD	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) February 22, 2012
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30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223
--

31. Date filed (Month, Day, Year) FEB 27 2012	32. Registrar's Signature Pamela E. Southall
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2012 07791

Reg. No.

1 - For
State
Registrar

Physician/
Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial transit.

1. Decedent's Name (First, Middle, Last) Fernando Bonilla Carranza				2. Date of Death Month February Day 17 , Year 2012	3. Time of Death 9:40 A M
4a. Facility Name (if not institution, give street and number) Holy Cross Hospital				4b. City, Town, or Location of Death Silver Spring	
5. Social Security Number none				6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. If Under 1 Year Months 1 Days 1 Hours 0 Min.
8. Date of Birth (Month, Day, Year) February 16, 2012				9. Birthplace (State or Foreign Country) Silver Spring, MD	
10a. State Maryland				10b. County Prince Georges	
10c. City, Town or Location Hyattsville				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 7008 23rd Avenue				10f. Zip Code 20783	10g. Citizen of What Country? United States
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No Specify: El Salvador	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Infant		16b. Kind of Business Industry Never Worked	
17. Father's Name (First, Middle, Last) Vidal Carranza				18. Mother's Name (First, Middle, Maiden Surname) Carmen Bonilla	
19a. Informant's Name/Relationship (Type, Print) Vidal Carranza, Father				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7008 23rd Avenue, Hyattsville, Maryland 20783	
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) 		20b. Place of Disposition (Name of cemetery, crematory or other place) Ft. Lincoln Crematory		Date 2/29/2012	20c. Location - City or Town, State Brentwood, Maryland
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Simple Tribute 1040 Rockville Pike, Rockville, Maryland 20852			
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Extreme Prematurity Approximate Interval Between Onset and Death 32 hours					
a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. _____					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred	
				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier 		29c. License number D55515		29d. Date signed (Month, Day, Year) 02/17/2012	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrea Lotz, 1500 Forest Glen Road, Silver Spring, Maryland 20910					
31. Date filed (Month, Day, Year) FEB 27 2012		32. Registrar's Signature 			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07792

1 - For
State
RegistrarPhysician/
Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mildred Chamberlain

2. Date of Death

Month

Day

Year

3. Time of Death

10:55 p M

Funeral
Director4a. Facility Name (if not institution, give street and number)
Civista Medical Center

4b. City, Town, or Location of Death

LaPlata

4c. County of Death

Charles

5. Social Security Number

577-36-3093

Usual Residence of Decedent

6. Sex

1 M 2 F

Yrs.

7. Age (in yrs. last birthday)

82

If Under 1 Year

If Under 24 Hrs.

Months

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)

02/23/1929

9. Birthplace (State or Foreign Country)

Washington, D.C.

10a. State

Maryland

10b. County

Charles

10c. City, Town or Location

Waldorf

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

11345 Raby Road

10f. Zip Code

20601

10g. Citizen of What Country?

U S A

11. Marital Status

1 Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

James Clarence Donaldson

18. Mother's Name (First, Middle, Maiden Surname)

Ida Louise Frye

19a. Informant's Name/Relationship (Type, Print)

Helen D. Hill/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1190 Bailey Bridge Rd., Limestone, TN 37641

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland VeteransCem. M00817

Date

20c. Location - City or Town, State

Cheltenham, MD

21. Signature of Funeral Service Licensee

▶ Dayton C. Echols II

22. Name and Address of Facility

Brinsfield-Echols F.H., P.A.

30195 Three Notch Rd., Charlotte Hall, MD 20622

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death

hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

ACUTE MYOCARDIAL INFARCTION

b. Due to (or as a consequence of):

ALTERED METABOLIC CARDIOVASCULAR DISEASE

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No
9 Unknown

23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (Specify)
9 Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

25. Was case referred to medical examiner?

1 Yes2 No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

Other:

4 Nursing Home 5 Residence 6 Other (Specify)

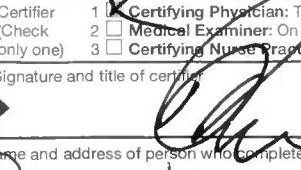
26. Place of Death (Check only one)

1 Inpatient2 ER/Outpatient3 DOA4 Nursing Home5 Residence6 Other (Specify)7 Nursing Home8 Residence9 Other (Specify)10 Nursing Home11 Residence12 Other (Specify)13 Nursing Home14 Residence15 Other (Specify)16 Nursing Home17 Residence18 Other (Specify)19 Nursing Home20 Residence21 Other (Specify)22 Nursing Home23 Residence24 Other (Specify)25 Nursing Home26 Residence27 Other (Specify)28 Nursing Home29 Residence30 Other (Specify)31 Nursing Home32 Residence33 Other (Specify)34 Nursing Home35 Residence36 Other (Specify)37 Nursing Home38 Residence39 Other (Specify)40 Nursing Home41 Residence42 Other (Specify)43 Nursing Home44 Residence45 Other (Specify)46 Nursing Home47 Residence48 Other (Specify)49 Nursing Home50 Residence51 Other (Specify)52 Nursing Home53 Residence54 Other (Specify)55 Nursing Home56 Residence57 Other (Specify)58 Nursing Home59 Residence60 Other (Specify)61 Nursing Home62 Residence63 Other (Specify)64 Nursing Home65 Residence66 Other (Specify)67 Nursing Home68 Residence69 Other (Specify)70 Nursing Home71 Residence72 Other (Specify)73 Nursing Home74 Residence75 Other (Specify)76 Nursing Home77 Residence78 Other (Specify)79 Nursing Home80 Residence81 Other (Specify)82 Nursing Home83 Residence84 Other (Specify)85 Nursing Home86 Residence87 Other (Specify)88 Nursing Home89 Residence90 Other (Specify)91 Nursing Home92 Residence93 Other (Specify)94 Nursing Home95 Residence96 Other (Specify)97 Nursing Home98 Residence99 Other (Specify)100 Nursing Home101 Residence102 Other (Specify)103 Nursing Home104 Residence105 Other (Specify)106 Nursing Home107 Residence108 Other (Specify)109 Nursing Home110 Residence111 Other (Specify)112 Nursing Home113 Residence114 Other (Specify)115 Nursing Home116 Residence117 Other (Specify)118 Nursing Home119 Residence120 Other (Specify)121 Nursing Home122 Residence123 Other (Specify)124 Nursing Home125 Residence126 Other (Specify)127 Nursing Home128 Residence129 Other (Specify)130 Nursing Home131 Residence132 Other (Specify)133 Nursing Home134 Residence135 Other (Specify)136 Nursing Home137 Residence138 Other (Specify)139 Nursing Home140 Residence141 Other (Specify)142 Nursing Home143 Residence144 Other (Specify)145 Nursing Home146 Residence147 Other (Specify)148 Nursing Home149 Residence150 Other (Specify)151 Nursing Home152 Residence153 Other (Specify)154 Nursing Home155 Residence156 Other (Specify)157 Nursing Home158 Residence159 Other (Specify)160 Nursing Home

161 <input type="

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

For AMEND#12 per FH State of Maryland / Department of Health and Mental Hygiene
State Registrar 3/2/2012 ACO HEALTH DEPT. CMH Certificate of Death Reg. No. 2012 07793

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) Gary Albert Combs						2. Date of Death Month Day Year February 20, 2012		3. Time of Death 9:15 A M	
Funeral Director		4a. Facility Name (if not institution, give street and number) 8241 Chalet Court			4b. City, Town, or Location of Death Millersville			4c. County of Death Anne Arundel			
To Be Completed by Funeral Director		5. Social Security Number 265-90-9917		6. Sex <input checked="" type="checkbox"/> X M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 64 Yrs.		If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) April 29, 1947	9. Birthplace (State or Foreign Country) New York	
		Usual Residence of Decedent MD		10b. County Anne Arundel		10c. City, Town or Location Millersville			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		10e. Street and Number 8241 Chalet Court			10f. Zip Code 21108			10g. Citizen of What Country? USA			
		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates. 1968-1980		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. Specify: White		
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) U.S. Army			16b. Kind of Business/Industry Federal Government			
		17. Father's Name (First, Middle, Last) Harvey Crosby			18. Mother's Name (First, Middle, Maiden Surname) Ann Shepherd						
		19a. Informant's Name/Relationship (Type, Print) Lorraine Combs / Wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8241 Chalet Court Millersville, MD 21108						
		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Metro Crematory, INC.		20b. Place of Disposition (Name of cemetery, crematory or other place) Feb. 23, 2012		20c. Location - City or Town, State Baltimore, MD					
		21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy, Severna Park, MD 21146						
Physician/ Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death			
		<p>a. Due to (or as a consequence of): Mycardial Infarction</p> <p>b. Due to (or as a consequence of): Hypertension</p> <p>c. Due to (or as a consequence of): Hypercholesterolemia</p> <p>d.</p>									
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year				
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. COPD						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown			
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)				
		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
		29b. Signature and title of certifier 		29c. License number DS4853			29d. Date signed (Month, Day, Year) 2/21/12				
		30. Name and address of person who completed cause of death (item 23a) (Type, Print) Danny Lee, MD, 1132 Annapolis Rd. MD 21113									
		31. Date filed (Month, Day, Year) FEB 24 2012		32. Registrar's Signature Danny J. Lee							
Division of Vital Records, P.O. Box 68760											
		To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit document.									
		CH 10/1									
		State Registrar									

Division of Vital Records, P.O. Box 687

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**State
Registrar**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 07794

Certificate of Death

Reg. No.

1- For
State
Registrar

Physician/
Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

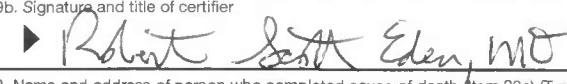
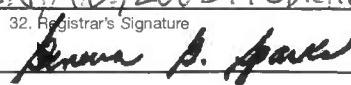
Physician/
Medical
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. Decedent's Name (First, Middle, Last) William S. Coppedge		2. Date of Death Month 02 Day 13 Year 2012		3. Time of Death 1855P M
4a. Facility Name (if not institution, give street and number) Anne Arundel Medical Center		4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arundel
5. Social Security Number 227-72-6013		6. Sex XX M 2 F	7. Age (In yrs. last birthday) 61 Yrs.	If Under 1 Year Months Days Hours Min.
Usual Residence of Decedent 10a. State Maryland		10b. County Anne Arundel		8. Date of Birth (Month Day, Year) Oct. 30, 1950
10c. City, Town or Location Annapolis				9. Birthplace (State or Foreign Country) California
10e. Street and Number 1766 Meadow Hill Drive		10f. Zip Code 21409		10g. Citizen of What Country? U.S.A.
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: 14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 4		16b. Kind of Business/Industry Systems Engineer/Sales
17. Father's Name (First, Middle, Last) John Oliver Coppedge		18. Mother's Name (First, Middle, Maiden Surname) Ann Driscoll		
19a. Informant's Name/Relationship (Type, Print) Jeanne A. Coppedge/wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1766 Meadow Hill Drive Annapolis, Maryland 21409		
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore Crematory		Date 2/18/2012
20c. Location - City or Town, State Baltimore, Maryland				
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401		
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Ventricular tachycardia		Approximate Interval Between Onset and Death a few minutes
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Coronary artery disease		several years
		Hypertension		many years
23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred
				28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. Signature and title of certifier 		29c. License number D30701		29d. Date signed (Month, Day, Year) 2/14/12
30. Name and address of person who completed cause of death (item 23a) (Type, Print) ROBERT SCOTT EDEN, MD, 2002 MEDICAL PKWY, ANNAPOLIS, MD 21401				
31. Date filed (Month, Day, Year) FEB 22 2012		32. Registrar's Signature 		

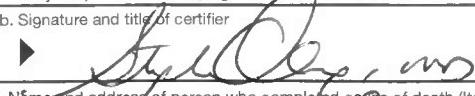
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend 23a, pt. 1 b-c, 25, 27, 28a-f, per me, g934 12-6-12 sm

1- For AMEND#19a Per FH
State of Maryland / Department of Health and Mental Hygiene
2/22/2012 AACO HEALTH DEPT CMH

Certificate of Death

Reg. No.

2012 07795

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Matthew Coyle							2. Date of Death Month Day Year February 13, 2012	3. Time of Death 4:30 AM		
	4a. Facility Name (if not institution, give street and number) Anne Arundel Medical Center			4b. City, Town, or Location of Death Annapolis			4c. County of Death Anne Arundel				
Funeral Director	5. Social Security Number 139-76-4587	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 40 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) 3/25/1971	9. Birthplace (State or Foreign Country) Wisconsin				
	Usual Residence of Decedent Maryland Anne Arundel		10c. City, Town or Location Annapolis			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
To Be Completed by Funeral Director	10e. Street and Number 119 Quiet Waters Place				10f. Zip Code 21403	10g. Citizen of What Country? USA					
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Manager			16b. Kind of Business/Industry Software					
	17. Father's Name (First, Middle, Last) Michael Coyle				18. Mother's Name (First, Middle, Maiden Surname) Barbara Stolle						
	19a. Mailing Name/Relationship (Type, Print) Mathilda Coyle - Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 119 Quiet Waters Place, Annapolis, MD 21403								
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore Crematory		Date 2/20/2012	20c. Location - City or Town, State Baltimore, Crematory					
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St, Annapolis, MD 21401								
Physician/ Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death		
Medical Certificate: To Be Completed by Physician/Medical Examiner	<p>a. <u>anoxic encephalopathy</u> Due to (or as a consequence of):</p> <p>b. <u>opiate use and Alcohol Intoxication</u> Due to (or as a consequence of):</p> <p>c. <u>ETOH</u> Due to (or as a consequence of):</p> <p>d. _____</p> <p style="text-align: right;"><i>Myelin T. Klobert</i> CERTIFICATION APPROVED BY MEDICAL EXAMINER</p>										
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown						23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year) fd: 2-6-12	28b. Time of injury unk AM	28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred subject ingested alcohol and opiates		28f. Location (Street and Number or Rural Route Number, City or Town, State) 119 Quiet Waters Pl. Annapolis ,MD.			
	29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
	29b. Signature and title of certifier 				29c. License number DS8510		29d. Date signed (Month, Day, Year) 02/13/12				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen Olexa AFMC								2001 Medical Parkway Annapolis, MD 21401		
State Registrar	31. Date filed (Month, Day, Year) FEB 22 2012		32. Registrar's Signature 								

Baltimore, Maryland 21215-0036

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

2012 07796

1- For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Ernest Ridgley Crapster III							2. Date of Death Month Day Year February 18, 2012	3. Time of Death 4:10P M	
	4a. Facility Name (if not institution, give street and number) Anne Arundel Medical Center				4b. City, Town, or Location of Death Annapolis			4c. County of Death Anne Arundel		
Funeral Director	5. Social Security Number 212-42-4270	6. Sex 1 X M 2 □ F	7. Age (In yrs. last birthday) 67 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) January 3, 1945	9. Birthplace (State or Foreign Country) Maryland			
To Be Completed by Funeral Director	10a. State Maryland	10b. County Anne Arundel	10c. City, Town or Location Riva					10d. Inside City Limits 1 □ Yes 2 X No		
	10e. Street and Number 372 Berkshire Drive				10f. Zip Code 21140			10g. Citizen of What Country? USA		
	11. Marital Status 1 □ Never Married 2 X Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 X No If Yes, Give Year or Dates. Elementary/Secondary (0-12) 12th			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 □ Yes 2 X No Specify: Web Pressman			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) 12th				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Web Pressman			16b. Kind of Business/Industry Printing		
	17. Father's Name (First, Middle, Last) Ernest R. Crapster, Jr.				18. Mother's Name (First, Middle, Maiden Surname) Mary Dorsey					
	19a. Informant's Name/Relationship (Type, Print) Fern H. Crapster/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 372 Berkshire Drive, Riva, MD 21140					
	20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Evangelical Presbyterian Church Cemetery			Date 2/23/2012	20c. Location - City or Town, State Annapolis, Maryland	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037					
	Physician/ Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Cerebrovascular Accident</u> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____								Approximate Interval Between Onset and Death 9 days
	Medical Certificate: To Be Completed by Physician/Medical Examiner	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		23c. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown					23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 X No 3 □ Probably 4 □ Unknown			
							24a. Was an autopsy performed? 1 □ Yes 2 X No			
							24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 X No			
25. Was case referred to medical examiner? 1 □ Yes 2 X No		26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 □ ER/Outpatient 3 □ DDA Other: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)								
27. Manner of Death 1 X Natural 2 □ Pending Investigation 2 □ Accident 3 □ Suicide 4 □ Homicide 5 □ Could not be determined		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? 1 □ Yes 2 □ No	28d. Describe how injury occurred				
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 □ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier 		29c. License number H0070482			29d. Date signed (Month, Day, Year) 2-18-12					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Keith Coulter 2001 Medical Parkway Annapolis, MD										
31. Date filed (Month, Day, Year) FEB 22 2012		32. Registrar's Signature 								

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 24a per med cert G925 3716/12 dk

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012

07797

1- For
State
Registrar

Physician/
Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

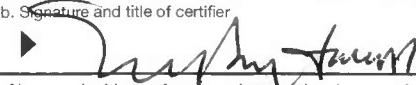
Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0036

Physician/
Medical
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		Helen Elizabeth Davis		2. Date of Death	Month Day Year				
				2	23	2012	1000 PM		
4a. Facility Name (if not institution, give street and number)		St. Mary's Nursing Center Inc		4b. City, Town, or Location of Death		Leonardtown			
4c. County of Death		St. Mary's County		3. Time of Death					
5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign Country)		
578546703		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	74 Yrs.	Months	Days	Hours Min.	Feb. 24, 1937 Maryland		
Usual Residence of Decedent		10a. State		10b. County		10c. City, Town or Location		10d. Inside City Limits	
		MD		St. Mary's		Clements		<input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number		10f. Zip Code		10g. Citizen of What Country?		US			
24391 Horseshoe Rd		20624							
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)		14. Race - American Indian, Black, White, etc.			
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		Specify: Black			
15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business Industry					
Elementary/Seconday (0-12) 11th		College (1-4 or 5+)		Housekeeper		Private			
17. Father's Name (First, Middle, Last)		Francis C. Carter		18. Mother's Name (First, Middle, Maiden Surname)		Mary Green			
19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)		19c. Date		20c. Location - City or Town, State			
Tawanda J. Brown/niece		24391 Horseshoe Rd Clements, MD 20624		3-1-2012		Bushwood, MD			
20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Date		20d. Location - City or Town, State			
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		Sacred Heart		3-1-2012		Bushwood, MD			
21. Signature of Funeral Service Licensee		22. Name and Address of Facility		23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.		Approximate Interval Between Onset and Death			
		BRISCOE-TONIC FUNERAL HOME 38576 Brett Way Mechanicsville, MD 20659		a. Due to (or as a consequence of): Atherosclerotic Cardio Vascular disease					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.		b. Due to (or as a consequence of):		c. Due to (or as a consequence of):		d.			
23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery		Month Day Year			
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		23f. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		23g. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one)		27. Manner of Death		28. Date of injury (Month, Day, Year)			
		Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28b. Time of injury M		28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Describe how injury occurred		28g. Location (Street and Number or Rural Route Number, City or Town, State)			
29b. Signature and title of certifier 		29c. License number D14285		29d. Date signed (Month, Day, Year) 2-24-12					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		31. Date filed (Month, Day, Year) FEB 27 2012		32. Registrar's Signature Karma S. Parker					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07798

1 - For
State
Registrar

1. Decedent's Name (First, Middle, Last)

James Saunders Duke

2. Date of Death

Month

Day

Year

February 24, 2012

3. Time of Death

2:15 p.m.

Physician/
Medical
Examiner

4a. Facility Name (if not institution, give street and number)

44328 Tall Timbers Road

4b. City, Town, or Location of Death

Tall Timbers

4c. County of Death

St. Mary's

Funeral
Director

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

To Be Completed by Funeral Director

5. Social Security Number

215-32-7835

6. Sex

M

F

7. Age (In yrs. last birthday)

78

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

02/10/1934

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

Maryland

10a. State

10b. County

10c. City, Town or Location

Tall Timbers

10d. Inside City Limits

Yes No

10e. Street and Number

44328 Tall Timbers Road

10f. Zip Code

20690

10g. Citizen of What Country?

United States

11. Marital Status

Never Married Married

Widowed Divorced

12. Was Decedent Ever in U.S. Armed Forces?

Yes No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Yes No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Cable Splicer

16b. Kind of Business/Industry

Telephone

17. Father's Name (First, Middle, Last)

Roland B. Duke

18. Mother's Name (First, Middle, Maiden Surname)

Lillian Drury

19a. Informant's Name/Relationship (Type, Print)

Mary Beth Kircher/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19116 Tyson Road, White Hall, MD 21161

Date

20c. Location - City or Town, State

20a. Method of Disposition

Burial Cremation Removal from State
 Donation Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Brinsfield-Echols Cre

02/27/2012

Charlotte Hall, MD

21. Signature of Funeral Service Licensee

Edward N. Brinsfield, Jr. M00052

22. Name and Address of Facility

Brinsfield Funeral Home, P.A.
22955 Hollywood Road, Leonardtown, MD 20650

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Acute myeloid leukemia

Approximate Interval Between Onset and Death

6 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

myelodysplastic syndrome

34 years

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

Yes No

Unknown

23c. If yes, outcome of pregnancy

Live Birth Fetal death Ectopic pregnancy
 Pregnant at time of death Other (Specify)

Unknown

23d. Date of delivery

Month Day Year

25. Was case referred to medical examiner?

Yes No

Hospital:

Inpatient ER/Outpatient DDA

26. Place of Death (Check only one)

Other: Nursing Home Residence Other (Specify)

27. Manner of Death

Natural
 Accident
 Suicide
 Homicide

Pending Investigation
 Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

Yes No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

► 650

29c. License number

050666

29d. Date signed (Month, Day, Year)

2/27/2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kurdeep S. Chhabra, MD 23415 Three Notch Rd, California, MD 20619

31. Date filed (Month, Day, Year)

FEB 28 2012

32. Registrar's Signature

Anna S. Park

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4 db
State
Registrar

DHMH 17 Rev 06-2011

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07799

1 - For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Thomas James Duclos					2. Date of Death Month Day Year February 18, 2012	3. Time of Death 11:37 a.m.			
	4a. Facility Name (if not institution, give street and number) St. Mary's Hospital			4b. City, Town, or Location of Death Leonardtown		4c. County of Death St. Mary's				
Funeral Director	5. Social Security Number 262-17-2755		6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 62 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) 11/11/1949	9. Birthplace (State or Foreign Country) New Hampshire		
	10a. State Maryland		10b. County St. Mary's		10c. City, Town or Location California		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
To Be Completed by Funeral Director	10e. Street and Number 22525 Johnson Pond Lane			10f. Zip Code 20619			10g. Citizen of What Country? United States			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Landscaper		16b. Kind of Business Industry Nursery					
	17. Father's Name (First, Middle, Last) Arthur A. Duclos				18. Mother's Name (First, Middle, Maiden Surname) Margaret Cadarette					
	19a. Informant's Name/Relationship (Type, Print) Michelle Duclos/Daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 45760 Nancy Lane, Great Mills, MD 20634						
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) Brinsfield-Echols Cre			20b. Place of Disposition (Name of cemetery, crematory or other place) Brinsfield-Echols Cre			Date 02/24/2012	20c. Location - City or Town, State Charlotte Hall, MD		
	21. Signature of Funeral Service Licensee Edward N. Brinsfield, Jr. M00052			22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 20650						
Physician/ Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Myocardial Infarction								Approximate Interval Between Onset and Death	
	b. Due to (or as a consequence of): Coronary Artery Disease								10 yrs.	
	c. Due to (or as a consequence of):									
	d. Due to (or as a consequence of):									
Physician/ Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown						23d. Date of delivery Month Day Year	
Medical Certificate: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Bowel Obstruction Peripheral Vascular Disease								23e. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
									24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred			
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								29b. Signature and title of certifier S. Michael J. D. M.D.	
									29c. License number D4284T	
									29d. Date signed (Month, Day, Year) 2/22/2012	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen T. Michael, MD St Mary's Hospital Leonardtown, MD 20650								31. Date filed (Month, Day, Year) FEB 28 2012	
	32. Registrar's Signature Anna S. Parker									

Thomas James Duclos
Division of Vital Records, P.O. Box 68760To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transitState
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07800

1 - For
State
Registrar

Physician/
Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last) John C. DeCosta							2. Date of Death Month February Day 17 , Year 2012	3. Time of Death 10:58 a.m.
4a. Facility Name (if not institution, give street and number) Bowie Health Center				4b. City, Town, or Location of Death Bowie			4c. County of Death Prince George's	
5. Social Security Number 225-64-0455		6. Sex M	7. Age (In yrs. last birthday) 63 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) Feb. 2, 1949	9. Birthplace (State or Foreign Country) Maryland	
10a. State MD		10b. County Prince George's		10c. City, Town or Location Bowie			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 14003 Heatherstone Drive				10f. Zip Code 20720			10g. Citizen of What Country? U.S.A.	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) General Contractor			16b. Kind of Business/Industry Department of Defense	
17. Father's Name (First, Middle, Last) Louis DeCosta				18. Mother's Name (First, Middle, Maiden Surname) Dorothy King				
19a. Informant's Name/Relationship (Type, Print) Sharon McCormick/wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14003 Heatherstone Dr., Bowie, MD 20715				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Columbia Gardens Cemetery			Date 2-22-2012	20c. Location - City or Town, State Arlington, Virginia
21. Signature of Funeral Service Licensee John DeCosta				22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, Maryland 20715				

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Coronary Artery Disease		Approximate Interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Diabetes Mellitus		
{		Chronic Kidney Disease		
a. Due to (or as a consequence of):				
b. Due to (or as a consequence of):				
c. Due to (or as a consequence of):				
d. Due to (or as a consequence of):				

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
--	---	---

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
--	--	--

24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
---	--

25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
---	---	--	--

27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work? M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
--	--	---------------------	--	-----------------------------------

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
--	--

29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	29c. License number 0101242050	29d. Date signed (Month, Day, Year) 2/21/2011
--	--	---

29b. Signature and title of certifier H. Chotani MD	29c. License number 0101242050	29d. Date signed (Month, Day, Year) 2/21/2011
---	--	---

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HABIB CHOTANI 4660 Kenmore Ave, Suite 600, Alexandria, VA 22304
--

31. Date filed (Month, Day, Year) FEB 23 2012	32. Registrar's Signature Suzanne J. Parker
---	---

ORIGINAL

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State
Registrar

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07801

1 - For
State
RegistrarPhysician/
Medical
Examiner1. Decedent's Name (First, Middle, Last)
Alleen M. Davenport2. Date of Death
Month **February** Day **20**, Year **2012**
3. Time of Death
9:52 A M4a. Facility Name (if not institution, give street and number)
Anne Arundel Medical Center4b. City, Town, or Location of Death
Annapolis4c. County of Death
Anne ArundelFuneral
Director5. Social Security Number
203-18-51336. Sex
 M F7. Age (In yrs. last birthday)
85 Yrs.If Under 1 Year
Months Days Hours Min.8. Date of Birth
(Month, Day, Year)
Sept. 16, 19269. Birthplace (State or Foreign
Country)
Pennsylvania

Usual Residence of Decedent

10a. State
Maryland10b. County
Anne Arundel

10c. City, Town or Location

Annapolis10d. Inside City Limits
 Yes No

10e. Street and Number

424 Blossom Tree Court10f. Zip Code
2140910g. Citizen of What Country?
U.S.A.

11. Marital Status

 Never Married Married
 Widowed Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
 Yes No
If Yes, Give
Year or Dates.13. Was Decedent of Hispanic Origin? (Specify Yes or No)
If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Yes No
Specify:14. Race - American Indian,
Black, White, etc.
Specify: **White**15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)**Analyst**16b. Kind of Business/Industry
Federal Government

17. Father's Name (First, Middle, Last)

Edward J. O'Brien

18. Mother's Name (First, Middle, Maiden Surname)

Marion Delaney19a. Informant's Name/Relationship (Type, Print)
Mary Cima/daughter19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
189 Duke of Gloucester St., Annapolis, Maryland 21401

20a. Method of Disposition

 Burial Cremation Removal from State
 Donation Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Holy Sepulchre Cem.

Date

20c. Location - City or Town, State

2/25/2012**Philadelphia, PA**

21. Signature of Funeral Service Licensee

Todd E. Liller

22. Name and Address of Facility

**John M. Taylor Funeral Home
147 Duke of Gloucester St., Annapolis, MD 21401**

To the Physician or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death

Aspiration pneumonia

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
 Yes No
 Unknown23c. If yes, outcome of pregnancy
 Live Birth Fetal death Ectopic pregnancy
 Pregnant at time of death Other (Specify)
 Unknown23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

metastatic pancreatic cancer

23e. Did tobacco use contribute to the cause of death?

 Yes No Probably Unknown25. Was case referred to medical examiner?
 Yes No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DCA

26. Place of Death (Check only one)

Other: Nursing Home Residence Other (Specify)

27. Manner of Death

1 Natural 5 Pending Investigation
2 Accident 6 Could not be determined
3 Suicide
4 Homicide28a. Date of injury
(Month, Day, Year)

28b. Time of injury

28c. Injury at work?

 Yes No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Rebecca Powell, MD

29c. License number

D72036

29d. Date signed (Month, Day, Year)

Feb 20, 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rebecca Powell 2001 Medical Parkway Annapolis MD 21401

31. Date filed (Month, Day, Year)

FEB 22 2012

32. Registrar's Signature

Rebecca Powell

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07802

1 - For
State
RegistrarPhysician/
Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last) Harry Edward Davis, Jr.			2. Date of Death Month Day Year February 17, 2012				3. Time of Death 12:20A M	
4a. Facility Name (if not institution, give street and number) Futurecare Chesapeake			4b. City, Town, or Location of Death Arnold				4c. County of Death Anne Arundel	
5. Social Security Number 577-40-3770		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) 11/28/1930	9. Birthplace (State or Foreign Country) Maryland	
10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Edgewater				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number 404 Salisbury Road				10f. Zip Code 21037			10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: Korean War		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)		16b. Kind of Business/Industry Truck Driver				
17. Father's Name (First, Middle, Last) Harry Edward Davis, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Mary Estelle Ziegler				
19a. Informant's Name/Relationship (Type, Print) Martha Davis/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 404 Salisbury Road, Edgewater, MD 21037				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lakemont Mem'l Gardens		Date 2/22/2012	20c. Location - City or Town, State Davidsonville, MD			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037				

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death			
a. End Stage Renal Disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. _____					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown			
		23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia, Peripheral Vascular Disease, Atrial Fibrillation		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier 		29c. License number D57531		29d. Date signed (Month, Day, Year) February 17, 2012	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mohit Negi, M.D. 8601 Veterans Hwy, Millersville, MD 21108					
31. Date filed (Month, Day, Year) FEB 22 2012		32. Registrar's Signature 			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07803

1- For State Registrar

Physician/
Medical Examiner

1. Decedent's Name (First, Middle, Last)	Joseph Thomas Diggs			2. Date of Death Month Month Day Year March 3, 2012	3. Time of Death 0155 hrs
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4a. Facility Name (if not institution, give street and number) Western Maryland Regional Medical Center	4b. City, Town, or Location of Death Cumberland			4c. County of Death Allegany	
--	--	--	--	---------------------------------	--

5. Social Security Number 215-42-4990	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 71 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (MM/DD/YYYY) Feb 28, 1941	9. Birthplace (State or Foreign Country) MD
--	--	---	---	---	--

10a. State MD	10b. County Allegany	10c. City, Town or Location LaVale			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
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10e. Street and Number 203 Forest Drive	10f. Zip Code 21502	10g. Citizen of What Country? USA
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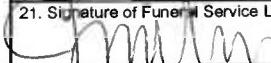
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify:	14. Race - American Indian, Black, White, etc. Specify: white
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15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Supervisor	16b. Kind of Business/Industry WSSC Water Co.
---	---	--

17. Father's Name (First, Middle, Last) Charles Sherman Diggs	18. Mother's Name (First, Middle, Maiden Surname) Patricia Diggs wife Beulah Christine Miller
--	--

19a. Informant's Name/Relationship (Type, Print) Patricia Diggs wife	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 203 Forest Drive LaVale MD 21502
---	---

20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify: Restlawn Memorial Gardens	20b. Place of Disposition (Name of cemetery, crematory or other place) Restlawn Memorial Gardens	Date 3/7/2012	20c. Location - City or Town, State LaVale MD
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21. Signature of Funeral Service Licensee 	22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue, Cumberland, MD 21502
--	---

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Contact Gunshot Wound of Head Due to (or as a consequence of):	Approximate Interval Between Onset and Death
--	--

b. Due to (or as a consequence of):	
--	--

c. Due to (or as a consequence of):	
--	--

d. Due to (or as a consequence of):	
--	--

<input type="checkbox"/> UNPENDED	<input type="checkbox"/> AMENDED	
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IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
--	---	---

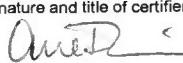
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
--	--

	24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
--	---	--

25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other	26. Place of Death (Check only one)
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27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day, Year) Mar 2, 2012	28b. Time of Injury 0000 hrs	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	28d. Describe how injury occurred Subject shot self
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28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Single Family Home	28f. Location (Street and Number or Rural Route Number, City or Town, State) 203 Forest Drive, Cumberland, MD
--	--

29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)	29b. Signature and title of certifier 	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) March 3, 2012
--	--	---------------------------------	--

30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

31. Date filed (Month, Day, Year) MAR 13 2012	32. Registered Signature 
--	---

Baltimore, MD 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Importants: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Medical Certification: To Be Completed by Physician/Medical Examiner

12
JM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07804

For
State
Registrar

Physician/
Medical
Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year	3. Time of Death Hour Minute AM/PM								
PETER S. EDWARDS		February 23, 2012 12:45 PM									
4a. Facility Name (if not institution, give street and number) 11058 SANANDREW DRIVE		4b. City, Town, or Location of Death NEW MARKET									
4c. County of Death FREDERICK		4d. Birthplace (State or Foreign Country) WASHINGTON, DC									
5. Social Security Number 579-35-9334		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 8 Yrs.								
8. If Under 1 Year Months Days Hours Min.		9. If Under 24 Hrs. Hours Min.									
10. Usual Residence of Decedent MARYLAND FREDERICK		11. Date of Birth (Month, Day, Year) Aug. 30, 2003									
12. State MARYLAND		13. County Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
14. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		15. Street and Number 11058 SANANDREW DRIVE									
16. Zip Code 21774		17. Citizen of What Country? USA									
18. Father's Name (First, Middle, Last) Mark Edwards		19. Mother's Name (First, Middle, Maiden Surname) Anna Peltsemes									
20a. Informant's Name/Relationship (Type, Print) Mark Edwards / Father		20b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11058 SANANDREW DR., NEW MARKET, MD 21774									
20c. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Resthaven Mem. Gard.		Date 2/28/2012	20d. Location - City or Town, State FREDERICK, MARYLAND								
21. Signature of Funeral Service Licensee Tony Troy Stauffer		22. Name and Address of Facility STAUFFER FUNERAL HOME 1621 OPOSSUMTOWN PIKE, FREDERICK, MD 21702									
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last											
<table border="1"> <tr> <td>a. <i>Respiratory Failure</i> Due to (or as a consequence of):</td> <td>Approximate Interval Between Onset and Death <i>1 day</i></td> </tr> <tr> <td>b. <i>Intrathoracic sepsis</i> Due to (or as a consequence of):</td> <td>Approximate Interval Between Onset and Death <i>5 days</i></td> </tr> <tr> <td>c. <i>Battone's disease (mucopolysaccharidosis)</i> Due to (or as a consequence of): <i>lipoarabinomucosidase</i></td> <td>Approximate Interval Between Onset and Death <i>birth</i></td> </tr> <tr> <td>d. _____</td> <td>_____</td> </tr> </table>				a. <i>Respiratory Failure</i> Due to (or as a consequence of):	Approximate Interval Between Onset and Death <i>1 day</i>	b. <i>Intrathoracic sepsis</i> Due to (or as a consequence of):	Approximate Interval Between Onset and Death <i>5 days</i>	c. <i>Battone's disease (mucopolysaccharidosis)</i> Due to (or as a consequence of): <i>lipoarabinomucosidase</i>	Approximate Interval Between Onset and Death <i>birth</i>	d. _____	_____
a. <i>Respiratory Failure</i> Due to (or as a consequence of):	Approximate Interval Between Onset and Death <i>1 day</i>										
b. <i>Intrathoracic sepsis</i> Due to (or as a consequence of):	Approximate Interval Between Onset and Death <i>5 days</i>										
c. <i>Battone's disease (mucopolysaccharidosis)</i> Due to (or as a consequence of): <i>lipoarabinomucosidase</i>	Approximate Interval Between Onset and Death <i>birth</i>										
d. _____	_____										
23b. IF FEMALE: Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown									
23d. Date of delivery Month Day Year											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown											
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year) 28b. Time of injury M 28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred									
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number Maryland D 0025462									
29b. Signature and title of certifier DAVID I. OTTO, MD		29d. Date signed (Month, Day, Year) 02/24/2012									
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID I. OTTO, MD. 405 FREDERICK RD. #216, CATONSVILLE, MD 21228											
31. Date filed (Month, Day, Year) FEB 27 2012		32. Registrar's Signature Debra S. Parker									

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07805

1- For
State
Registrar

Physician/
Medical
Examiner

Baltimore, Maryland 21215-0036
To Be Completed by Funeral Director
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
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within 24 hours after death.
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completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last)

Marilyn Elizabeth Ekstrom

2. Date of Death

Month Day Year

3. Time of Death

05:56 M

4a. Facility Name (if not institution, give street and number)

Bowie Health Care Center

4b. City, Town, or Location of Death

Bowie

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

357-30-7648

Usual Residence of Decedent

6. Sex

1 M 2 F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days Hours Min.

8. Date of Birth

(Month, Day, Year)

03/21/1933

9. Birthplace (State or Foreign Country)

West Virginia

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Bowie

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

4706 Ramsgate Lane

10f. Zip Code

20715

10g. Citizen of What Country?

U. S. A.

11. Marital Status

1 Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No)
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.
Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Home Maker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Clarence Brickey

18. Mother's Name (First, Middle, Maiden Surname)

Mary Philippi

19a. Informant's Name/Relationship (Type, Print)

Anne Curtis/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4443 Wells Parkway, Hyattsville, MD 20782

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Huntt Crematory

Date

2/21/2012

20c. Location - City or Town, State

Waldorf, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Robert E. Evans Funeral Home,

16000 Annapolis Road, Bowie, Maryland 20715

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death

Complications from Cerebrovascular Accident

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. _____

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No

9 Unknown

23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (Specify)

9 Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

23f. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

1 Inpatient

2 ER/Outpatient

3 DDA

Other:

4 Nursing Home

5 Residence

6 Other (Specify)

26. Place of Death (Check only one)

27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D43351

29d. Date signed (Month, Day, Year)

02/16/2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Ikechi Okwara, 12200 Annapolis Road #316, Glenn Dale, Maryland 20769

31. Date filed (Month, Day, Year)

FEB 22 2012

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07806

1 - For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Rita Esker							2. Date of Death Month Day Year February 19, 2012	3. Time of Death 2:55 A M		
	4a. Facility Name (if not institution, give street and number) Arden Courts				4b. City, Town, or Location of Death Silver Spring			4c. County of Death Montgomery			
Funeral Director	5. Social Security Number 322-20-9068	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 86	Yrs.	If Under 1 Year Months Days Hours Min.	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Jan. 8, 1926	9. Birthplace (State or Foreign Country) Illinois			
To Be Completed by Funeral Director	10a. State Virginia				10b. County Stafford	10c. City, Town or Location Stafford			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number 21 Meridian Road				10f. Zip Code 22556			10g. Citizen of What Country? U.S.A.			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 1				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home			
	17. Father's Name (First, Middle, Last) John Dieterich Zumbahlen				18. Mother's Name (First, Middle, Maiden Surname) Catherine Anne Lake						
	19a. Informant's Name/Relationship (Type, Print) Francine Glavy/daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21 Meridian Road Stafford, Virginia 22556						
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore Crematory		Date 2/22/2012	20c. Location - City or Town, State Baltimore, Maryland					
	21. Signature of Funeral Service Licensee Mexlin T. Alpert				22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401						
Physician/ Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Alzheimer Disease								Approximate Interval Between Onset and Death		
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown										
	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____								23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension Osteoporosis								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								26. Place of Death (Check only one) <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) ALF		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred				
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Only one <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								29b. Signature and title of certifier D. Darryl Hill	29c. License number 53235	29d. Date signed (Month, Day, Year) 2/20/12
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Darryl Hill 13635 Baltimore Avenue Laurel, MD 20707										
	31. Date filed (Month, Day, Year) FEB 22 2012				32. Registrar's Signature Renata P. Parker						

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

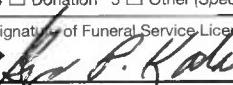
Certificate of Death

Reg. No.

2012 07807

1- For
State
Registrar

**Physician/
Medical
Examiner**

		1. Decedent's Name (First, Middle, Last)			2. Date of Death			3. Time of Death		
		Joan L. Earnshaw			Month Day Year			4:15P M		
		4a. Facility Name (if not institution, give street and number) 1054 Marywood Drive			4b. City, Town, or Location of Death Davidsonville			4c. County of Death Anne Arundel		
Funeral Director		5. Social Security Number 219-34-1952	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 74 Yrs.	If Under 1 Year Months Days Hours Min.	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) April 8, 1937	9. Birthplace (State or Foreign Country) Maryland		
To Be Completed by Funeral Director		10a. State Maryland	10b. County Anne Arundel	10c. City, Town or Location Davidsonville			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
		10e. Street and Number 1054 Marywood Drive	10f. Zip Code 21035			10g. Citizen of What Country? USA				
		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Counselor/Psychologist			16b. Kind of Business/Industry Federal Government			
		17. Father's Name (First, Middle, Last) Edward W. Larrimore	18. Mother's Name (First, Middle, Maiden Surname) Alma Sherbert							
		19a. Informant's Name/Relationship (Type, Print) George Earnshaw/Husband	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1054 Marywood Drive, Davidsonville, MD 21035							
		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) Kalas Crematory	Date 2/20/2012			20c. Location - City or Town, State Edgewater, Maryland			
		21. Signature of Funeral Service Licensee 	22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, Md. 21037							
Physician/ Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)						Approximate Interval Between Onset and Death Years		
		a. <i>Congestive Heart Failure</i> Due to (or as a consequence of): <i>Mitral regurgitation</i>						Years		
		b. Due to (or as a consequence of):								
		c. Due to (or as a consequence of):								
		d. Due to (or as a consequence of):								
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Chronic neck + back pain, migraine headaches, breast cancer, anemia, osteoporosis</i>						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
		25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
		29b. Signature and title of certifier 		29c. License number D46992			29d. Date signed (Month, Day, Year) 2/20/2012			
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tara T. Muscovich MD 1438 Defense Hwy Gambrills, MD 21054								
State Registrar		31. Date filed (Month, Day, Year) FEB 22 2012		32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

DHMH 17 Rev 06-2011

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07808

1 - For
State
RegistrarPhysician/
Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Physician or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) ROSALIE FREELAND			2. Date of Death Month Day Year FEBRUARY 19, 2012	3. Time of Death 1:28 PM
4a. Facility Name (if not institution, give street and number) 7905 Daniel Drive			4b. City, Town, or Location of Death Forestville	
4c. County of Death Prince George's				
5. Social Security Number 373-20-6376			6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) 87 Yrs.
			If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.
8. Date of Birth (Month, Day, Year) Apr. 30, 1924			9. Birthplace (State or Foreign Country) GA	
Usual Residence of Decedent 10a. State MD 10b. County Prince Georges 10c. City, Town or Location Forestville 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
10e. Street and Number 7905 Daniel Drive			10f. Zip Code 20747	10g. Citizen of What Country? USA
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates KOREAN	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Registered Nurse	16b. Kind of Business Industry Nursing	
17. Father's Name (First, Middle, Last) Charlie H. Range			18. Mother's Name (First, Middle, Maiden Surname) Hattie Johnson	
19a. Informant's Name/Relationship (Type, Print) Andre Freeland/son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7905 Daniel Drive Forestville, MD 20747	
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Plum Pt. UMC Cem.		20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 2/25/2012	20c. Location - City or Town, State Huntingtown, MD
21. Signature of Funeral Service Licensee Blader A. Sewell		22. Name and Address of Facility Sewell Funeral Home, P.A. 1451 Dares Beach Rd. Prince Fred., MD 20678		
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
<p>METASTATIC BREAST CANCER</p> <p>a. Due to (or as a consequence of):</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. _____</p>				
Approximate Interval Between Onset and Death				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28d. Describe how injury occurred	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number MD# 33255	29d. Date signed (Month, Day, Year) FEBRUARY 22, 2012	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KAREN ANN BLACKSTONE, M.D., VAMC 50 IRVING ST. NW, WASHINGTON, DC 20422/688				
31. Date filed (Month, Day, Year) FEB 24 2012		32. Registrar's Signature Suzanne S. Parker		

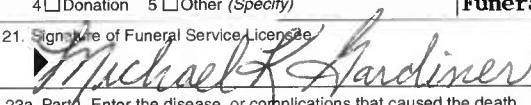
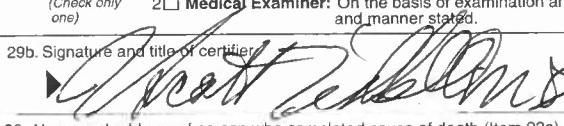
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07809

1 - For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ARMAND J. FERRARO				2. Date of Death Month Day Year February 24, 2012 12:09a M	3. Time of Death M	
	4a. Facility Name (If not institution, give street and number) St. Mary's Hospital		4b. City, Town, or Location of Death Leonardtown		4c. County of Death St. Mary's		
Funeral Director	5. Social Security Number 107-58-9657	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 43 Yrs.	If Under 1 Year Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 06/18/1968	9. Birthplace (State or Foreign Country) New York		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State Maryland 10b. County St. Mary's 10c. City, Town or Location California				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number 22087 Willis Drive		10f. Zip Code 20619		10g. Citizen of What Country? U S A		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: White		
	17. Father's Name (First, Middle, Last) Armand Joseph Ferraro		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Executive Chef		16b. Kind of Business/Industry Culinary Arts		
	19a. Informant's Name/Relationship (Type, Print) Armand J. Ferraro/Father		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1169 Wyndemere Circle, Longmont, CO 80504		18. Mother's Name (First, Middle, Maiden Surname) Mary Ann Brennan		
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) 21. Signature of Funeral Service Licensee 		20b. Place of Disposition (Name of cemetery, crematory or other place) Mattingley-Gardiner Funeral Home, P.A. Crematory		Date 02/25/2012	20c. Location - City or Town, State Leonardtown, MD	
Physician /Medical Examiner	<p>23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.</p> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> <p>a. Myocardial Infarction Due to (or as a consequence of): CORONARY ARTERY DISEASE</p> <p>b. Due to (or as a consequence of): Poorly Controlled Diabetes - Type I</p> <p>c. Due to (or as a consequence of): ASTHMA</p> <p>d.</p> <p>Approximate Interval Between Onset and Death 10 MIN</p> <p>5 Months</p> <p>33 years</p>						
Medical Certification: To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year		
	<p>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</p> <p>ASTHMA</p> <p>23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown</p>						
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
	29b. Signature and title of certifier 		29c. License number 852196		29d. Date signed (Month, Day, Year) 2-24-2012		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. Scott Tidball MD 23415 Three Notch Rd. Ste 2054 California, MD 20619		31. Date filed (Month, Day, Year) FEB 27 2012 32. Registrar's Signature 				

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(8) ab

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07810

1 - For
State
RegistrarPhysician/
Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

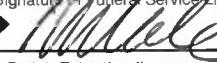
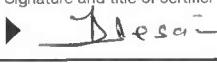
Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Physician or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death	
ALLAN FOWLER		Feb	17	2012	11:30 PM		
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death				4c. County of Death	
FutureCare		Baltimore				Maryland	
5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (in yrs. last birthday) 57 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month Day Year) 3/24/1954	9. Birthplace (State or Foreign Country) Maryland
10a. State Maryland		10b. County Anne Arundel				10c. City, Town or Location Arnold	
10e. Street and Number 305 College Parkway		10f. Zip Code 21012				10g. Citizen of What Country? USA	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Roofer		16b. Kind of Business Industry Roofing			
17. Father's Name (First, Middle, Last) David Fowler				18. Mother's Name (First, Middle, Maiden Surname) Gertrude Skoch			
19a. Informant's Name/Relationship (Type, Print) Shannon Fowler/ Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8006 Corkberry Ln., Apt. 304, Pasadena, MD 21122					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Kalas Crematory		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date 2/24/12	20c. Location - City or Town, State Edgewater, MD		
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
Immediate Cause (Final disease or condition resulting in death)							
Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
<p>a. <u>Septic shock</u> Due to (or as a consequence of):</p> <p>b. <u>pneumonia</u> Due to (or as a consequence of):</p> <p>c. <u>Respiratory failure</u> Due to (or as a consequence of):</p> <p>d. <u>organic brain syndrome</u> Due to (or as a consequence of):</p>							
Approximate Interval Between Onset and Death 1 week							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) 9/Unknown				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>SEIZURES</u>							
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier 		29c. License number D 30494				29d. Date signed (Month, Day, Year) 01/23/2012	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) K DESAI MD 716 maiden choice lane suite 302 Baltimore MD 21228							
31. Date filed (Month, Day, Year) FEB 24 2012		32. Registrar's Signature 					

Eileen Marie Foley

12-01426

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State
Registrar Amend #17 per FH 2/27/2012 cchd/ba Certificate of Death

Reg. No.

2012 07811

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) Eileen Marie Foley						2. Date of Death Month Day Year February 17, 2012		3. Time of Death 2358 hrs	
Funeral Director		4a. Facility Name (if not institution, give street and number) Route 5 at Surratts Road			4b. City, Town, or Location of Death Clinton			4c. County of Death Prince George's			
To Be Completed by Funeral Director		5. Social Security Number 213 96 1200		6. Sex 1 M 2 X F		7. Age (In yrs. last birthday) 46 Yrs.		If Under 1 Year Months Days Hours Min. 		8. Date of Birth (MM/DD/YYYY) 10/04/1965	
To Be Completed by Funeral Director		9. Birthplace (State or Foreign Country) PA		10a. State MD		10b. County Prince George's		10c. City, Town or Location Temple Hills		10d. Inside City Limits 1 XX Yes 2 No	
To Be Completed by Funeral Director		10e. Street and Number 2601 Easton Street			10f. Zip Code 20748			10g. Citizen of What Country? USA			
To Be Completed by Physician/Medical Examiner		11. Marital Status 1 Never Married 2 X Married		12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 X No		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Yes 2 X No specify:		14. Race - American Indian, Black, White, etc. Specify: White			
To Be Completed by Physician/Medical Examiner		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Catering Assistant			16b. Kind of Business/Industry Private			
To Be Completed by Physician/Medical Examiner		17. Father's Name (First, Middle, Last) Grover Earl Ebersole Ebersole			18. Mother's Name (First, Middle, Maiden Surname) Bonnie Lee Burke						
To Be Completed by Physician/Medical Examiner		19a. Informant's Name/Relationship (Type, Print) John D. Foley/ Husband			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2601 Easton St. Temple Hills, MD 20748						
To Be Completed by Physician/Medical Examiner		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State			20b. Place of Disposition (Name of cemetery, crematory or other place) Resurrection Cem.			Date 2/28/2012	20c. Location - City or Town, State Clinton, MD		
To Be Completed by Physician/Medical Examiner		21. Signature of Funeral Service Licensee Sweeney Bruce Foley			22. Name and Address of Facility Riscoe-Tonic Funeral Home						
To Be Completed by Physician/Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)			23b. Due to (or as a consequence of): a. Multiple Injuries			23c. Approximate Interval Between Onset and Death			
To Be Completed by Physician/Medical Examiner		23d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			23e. Due to (or as a consequence of): b. c. d.						
To Be Completed by Physician/Medical Examiner		<input type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDEO									
To Be Completed by Physician/Medical Examiner		23f. IF FEMALE: 23g. Was decedent pregnant in the past 12 months? 1 X Yes 2 No 9 X Unknown			23h. If yes, outcome of pregnancy 1 X Live birth 2 X Fetal death 3 X Ectopic pregnancy 4 X Pregnant at time of death 5 X Other (Specify)			23i. Date of delivery Month Day Year			
To Be Completed by Physician/Medical Examiner		23j. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			23k. Did tobacco use contribute to the cause of death? 1 X Yes 2 X No 3 X Probably 4 X Unknown						
To Be Completed by Physician/Medical Examiner		23l. 23m. Was case referred to medical examiner? 1 X Yes 2 X No			23n. Hospital: 1 X Inpatient 2 X ER/Outpatient 3 X DOA			23o. Place of Death (Check only one) Other: 4 X Nursing Home 5 X Residence 6 X Other: Scene			
To Be Completed by Physician/Medical Examiner		23p. 23q. Manner of Death 1 X Natural 5 X Pending Investigation 2 X Accident 6 X Could not be determined 3 X Suicide 4 X Homicide			23r. 23s. Date of Injury (Month, Day, Year) FOUND: Feb 17, 2012			23t. 23u. Time of Injury 2358 hrs			
To Be Completed by Physician/Medical Examiner		23v. 23w. Injury at Work? 1 X Yes 2 X No			23x. 23y. Describe how injury occurred Pedestrian struck by vehicle						
To Be Completed by Physician/Medical Examiner		23z. 23aa. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Interstate/Express			23cc. 23dd. Location (Street and Number or Rural Route Number, City or Town, State) Route 5 at Surratts Road, Clinton, MD						
To Be Completed by Physician/Medical Examiner		23ee. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			23ff. Signature and title of certifier J.M. JE			23gg. License number O.C.M.E.			
To Be Completed by Physician/Medical Examiner		23hh. Name and address of person who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223			23ii. Date signed (Month, Day, Year) February 18, 2012						
State Registrar		31. Date filed (Month, Day, Year) FEB 27 2012			32. Registrar's Signature Eileen J. Foley						

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Baltimore, MD 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Ba-1
Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
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Physician / Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07812

1 - For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Ernestine Joan Grogg							2. Date of Death Month Day Year February 20, 2012	3. Time of Death 1514 P M	
	4a. Facility Name (if not institution, give street and number) 17360 Old Frederick Road				4b. City, Town, or Location of Death Mt. Airy			4c. County of Death Howard		
Funeral Director	5. Social Security Number 213-40-5969	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 68 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) Apr. 24, 1943	9. Birthplace (State or Foreign Country) Washington, DC			
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland	10b. County Howard	10c. City, Town or Location Mt. Airy				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	10e. Street and Number 17360 Old Frederick Road		10f. Zip Code 21771			10g. Citizen of What Country? United States				
Physician/ Medical Examiner	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Beautician				16b. Kind of Business/Industry Hair Care	
17. Father's Name (First, Middle, Last) Horace Kermit Hancock					18. Mother's Name (First, Middle, Maiden Surname) Kathryn Fitchett					
19a. Informant's Name/Relationship (Type, Print) Charles E. Grogg, Jr. / Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17360 Old Frederick Road Mt. Airy, Maryland 21771						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>► Oog Jato</i>			20b. Place of Disposition (Name of cemetery, crematory or other place) Pine Grove Cemetery			Date February 26, 2012	20c. Location - City or Town, State Mt. Airy, Maryland			
21. Signature of Funeral Service Licensee <i>► Oog Jato</i>				22. Name and Address of Facility Stauffer Funeral Homes, P.A. 8 E. Ridgeville Blvd. Mt. Airy, Maryland 21771						
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									Approximate Interval Between Onset and Death Years	
<p>a. <i>Arterio Sclerotic Cardiovascular Disease</i> Due to (or as a consequence of):</p> <p>b. <i>Hypertension</i> Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. _____</p>										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred				
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>► Charles W. Karesh, M.D.</i>							29c. License number D21726	29d. Date signed (Month, Day, Year) February 21, 2012
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles W. Karesh, M.D. 26033 Ridge Road Damascus, Maryland 20872										
31. Date filed (Month, Day, Year) FEB 27 2012		32. Registrar's Signature <i>► Bruce J. Gavel</i>								

Baltimore, Maryland 21215-0036

Permit Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07813

1 - For
State
RegistrarPhysician/
Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/
Medical
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

William William 21/12/2012
 Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial slip.

20
 State
Registrar

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death Hour Minute AM PM	
William Granik		Sep 21 2012				0130 M	
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death				4c. County of Death	
Suburban Hospital		Bethesda				Montgomery	
5. Social Security Number	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 74 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 08/10/1937	9. Birthplace (State or Foreign Country) New York, NY	
Usual Residence of Decedent							
10a. State MD	10b. County Montgomery		10c. City, Town or Location Bethesda				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number 9217 East Parkhill Drive			10f. Zip Code 20814			10g. Citizen of What Country? United States	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 54		16b. Kind of Business/Industry Attorney			
17. Father's Name (First, Middle, Last) Theodore S. Granik				18. Mother's Name (First, Middle, Maiden Surname) Hannah Hayne			
19a. Informant's Name/Relationship (Type, Print) Debra Granik - daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 55 East 11th Street New York, NY 10003				
20a. Method of Disposition 1 <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) National Crematory			Date 02/22/12	20c. Location - City or Town, State Falls Church, VA	
21. Signature of Funeral Service Licensee ►		22. Name and Address of Facility Edward Sagel Funeral Direction Inc 1091 Rockville Pike Rockville MD 20852					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): Scbdural hematoma b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death 2/22/12							
23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DCA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year) Aug 29 2011		28b. Time of injury 1600 M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	28d. Describe how injury occurred Fall on driveway	
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Neighboring driveway		28f. Location (Street and Number or Rural Route Number, City or Town, State) 9217 East Parkhill Bethesda, MD 20814					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number D62949			29d. Date signed (Month, Day, Year) 2/21/12		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Natasha Haag 8600 OLD GEORGETOWN ROAD BETHESDA MD 20814							
31. Date filed (Month, Day, Year) FEB 27 2012		32. Registrar's Signature Lorraine B. Farrel					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07814

1- For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Joy Renee Golden							2. Date of Death Month Day Year February 21, 2012	3. Time of Death 11:31 A M	
	4a. Facility Name (if not institution, give street and number) 7817 Laurel Leaf Drive			4b. City, Town, or Location of Death Potomac			4c. County of Death Montgomery			
Funeral Director	5. Social Security Number 577-56-0021	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 70 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) 07/22/1941	9. Birthplace (State or Foreign Country) Washington, DC			
To Be Completed by Funeral Director	10a. State MD	10b. County Montgomery	10c. City, Town or Location Potomac					10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number 7817 Laurel Leaf Drive				10f. Zip Code 20854			10g. Citizen of What Country? United States		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Real Estate Management			16b. Kind of Business/Industry Real Estate			
	17. Father's Name (First, Middle, Last) Philip Diatz				18. Mother's Name (First, Middle, Maiden Surname) Sonia Yosgour					
	19a. Informant's Name/Relationship (Type, Print) Rodney Golden-Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7817 Laurel Leaf Drive Potomac, MD 20854					
Physician/ Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Judean Mem. Gardens			Date 02/23/2012	20c. Location - City or Town, State Olney, Maryland			
Medical Certificate: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Mollie C. B.		22. Name and Address of Facility Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Rockville, MD 20852							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metastatic Breast Cancer								Approximate Interval Between Onset and Death 2 yr, 10 mo	
	<p>a. Due to (or as a consequence of): Bilateral Breast Cancer</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. _____</p>									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred				
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	29b. Signature and title of certifier Carolyn B. Hendricks, MD		29c. License number D37236			29d. Date signed (Month, Day, Year) February 23, 2012				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Carolyn Hendricks, MD 6410 Rockledge Drive, #506 Bethesda, MD 20817									
State Registrar	31. Date filed (Month, Day, Year) FEB 27 2012		32. Registrar's Signature Janice S. Farrel							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07815

1 - For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Jessie M. Gott							2. Date of Death Month February Day 17 Year 2012	3. Time of Death 2:00 PM
	4a. Facility Name (if not institution, give street and number) Heritage Harbour Health & Rehabilitation			4b. City, Town, or Location of Death Annapolis			4c. County of Death Anne Arundel		
Funeral Director	5. Social Security Number 217-38-8516	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month Day Year) 03-05-1929	9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent 10a. State MD 10b. County Anne Arundel			10c. City, Town or Location Galesville			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 4722 Woodfield Road				10f. Zip Code 20765			10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) School Teacher			16b. Kind of Business Industry Anne Arundel County Public School				
17. Father's Name (First, Middle, Last) Albert Wilbur Woodfield, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Louise M. Hopkins					
19a. Informant's Name/Relationship (Type, Print) Vernon T. Gott, Jr., Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 73, Galesville, MD 20765					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Woodfield Cemetery			Date 02-24-2012	20c. Location - City or Town, State Galesville, MD			
21. Signature of Funeral Service Licensee William R. Gross		22. Name and Address of Facility Rausch Funeral Home, P.A.			22. Name and Address of Facility 8325 Mt. Harmony Lane, Owings, MD 20736				
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		<i>Cardiac Amyloid</i>							
		a. Due to (or as a consequence of):							
		b. Due to (or as a consequence of):							
		c. Due to (or as a consequence of):							
		d. _____							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year				Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Failure to thrive					23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician <input type="checkbox"/> Medical Examiner <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier D		29c. License number DS1028			29d. Date signed (Month, Day, Year) February 22, 2012				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Aditya Chopra 100 Ridgely Ave Ste 231 Annapolis MD 21401									
31. Date filed (Month, Day, Year) FEB 24 2012		32. Registrar's Signature James S. Spawls							

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

dear 10
State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07816

1 - For
State
Registrar

Physician/
Medical
Examiner

1. Decedent's Name (First, Middle, Last) Charles Albert Guyer, Jr.		2. Date of Death Month Day Year February 18, 2012	3. Time of Death AM
4a. Facility Name (if not institution, give street and number) Charlotte Hall Veterans Home		4b. City, Town, or Location of Death Charlotte Hall	
4c. County of Death St. Mary's			
5. Social Security Number 579-26-9641		6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 86 Yrs.
8. If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
9. Birthplace (State or Foreign Country) Washington, DC		10. Inside City Limits 1 Yes 2 No	
10a. State MD		10b. County St. Mary's	
10c. City, Town or Location Charlotte Hall		10d. Inside City Limits 1 Yes 2 No	
10e. Street and Number 29449 Charlotte Hall Road		10f. Zip Code 20622	
10g. Citizen of What Country? USA			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates.	
13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: X		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Gas Conversion	
16b. Kind of Business/Industry Heating and Air Conditioning			
17. Father's Name (First, Middle, Last) Charles Albert Guyer, Sr.		18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Egan	
19a. Informant's Name/Relationship (Type, Print) Susan E. Toth / Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 45511 Westmeath Way, D-12, Great Mills, MD 20634	
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Cem	
		Date 02/24/2012	20c. Location - City or Town, State Cheltenham, Maryland
21. Signature of Funeral Service Licensee <i>Marylyn C. Echols, HT #M00817</i>		22. Name and Address of Facility Brinsfield-Echols F.H., P.A. 30195 Three Notch Road, Charlotte Hall, MD 20622	
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death	
a. Due to (or as a consequence of): DEMENTIA			
b. Due to (or as a consequence of):			
c. Due to (or as a consequence of):			
d. Due to (or as a consequence of):			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown	
23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. COLON CANCER		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) ASSISTED LIVING	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year) 28b. Time of injury M 28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number D12906	
29d. Date signed (Month, Day, Year) 2/28/12			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Janice V. Kautzman, MD, 2070 Old Line Center #207, Waldorf, MD 20602			
31. Date filed (Month, Day, Year) FEB 27 2012		32. Registrar's Signature Janice V. Kautzman	

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Division of Vital Records, P.O. Box 68760

State
Registrar

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07817

1- For
State
RegistrarPhysician/
Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

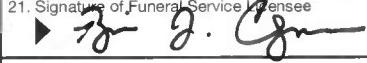
Permit: Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/
Medical
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

1. Decedent's Name (First, Middle, Last) Florence Greenfield		2. Date of Death Month 02 Day 22 Year 2012		3. Time of Death 7:30 AM
4a. Facility Name (if not institution, give street and number) 1 Bay Dr.		4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arundel
5. Social Security Number 215-03-4847		6. Sex 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 96 Yrs.	If Under 1 Year Months Days Hours Min.
Usual Residence of Decedent MD Anne Arundel		8. Date of Birth (Month, Day, Year) 11/26/1915		
10a. State MD		10b. County Anne Arundel		10d. Inside City Limits 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number 1 Bay Dr.		10f. Zip Code 21403		10g. Citizen of What Country? USA
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Owner/Operator		16b. Kind of Business/Industry Retail Clothing
17. Father's Name (First, Middle, Last) Samuel Gross		18. Mother's Name (First, Middle, Maiden Surname) Hilda Cline		
19a. Informant's Name/Relationship (Type, Print) Rosalind Katcef daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3129 Catrina Lane Annapolis, MD 21403		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Kneseth Israel Cemetery		Date 2/23/2012
20c. Location - City or Town, State Annapolis, Md				
21. Signature of Funeral Service licensee 		22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401		
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Coronary Artery Disease		Approximate Interval Between Onset and Death 10 years		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. Due to (or as a consequence of):				
b. Due to (or as a consequence of):				
c. Due to (or as a consequence of):				
d. _____				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work? M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) At home		28d. Describe how injury occurred
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		28f. Location (Street and Number or Rural Route Number, City or Town, State) CT suite 201 Annapolis, MD 21401		
29b. Signature and title of certifier 		29c. License number DS7819		29d. Date signed (Month, Day, Year) 2/22/2012
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Matthew Malty 132 Holiday CT suite 201 Annapolis, MD 21401				
31. Date filed (Month, Day, Year) FEB 24 2012		32. Registrar's Signature 		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07818

1- For
State
RegistrarPhysician/
Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Tommy Lee Guest

2. Date of Death

Month

Day

Year

3. Time of Death

M

4a. Facility Name (if not institution, give street and number)

Laurel Regional Hospital

4b. City, Town, or Location of Death

Laurel

4c. County of Death

Prince George's

5. Social Security Number

212 08 3442

6. Sex

1 M 2 F

7. Age (In yrs. last birthday)

37 Yrs.

If Under 1 Year

If Under 24 Hrs.

8. Date of Birth

3. Time of Death

Months

Days

Hours

Min.

(Month, Day, Year)

3/6/1974

1505 M

Usual Residence of Decedent

MD

10b. County

10c. City, Town or Location

10d. Inside City Limits

Prince George's

Lanham

1 Yes 2 No

10e. Street and Number

8200 Good Luck Road

10f. Zip Code

20706

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) 12

College (1-4 or 5+) 1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Thomas Guest

18. Mother's Name (First, Middle, Maiden Surname)

Carolyn Lewis

19a. Informant's Name/Relationship (Type, Print)

Thomas Guest/ Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5812 Nystrom St. New Carrollton, MD 20784

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Crem.

Date

20c. Location - City or Town, State

3/3/2012 Beltsville, MD

21. Signature of Funeral Service Licensee

Gimbley Briscoe-Tonic

22. Name and Address of Facility

Briscoe-Tonic Funeral Home
2294 old Washington Rd. Waldorf, MD 20601

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death
<p>a. Due to (or as a consequence of): <i>Cervical Spine Fractures</i></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>				
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Diabetes</i> <i>Hypertension</i>		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No

25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide	28a. Date of injury (Month, Day, Year) October 2007 afternoon 28b. Time of injury 28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 28d. Describe how injury occurred <i>car crash when he lost control</i>
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) STREET	28f. Location (Street and Number or Rural Route Number, City or Town, State) 9200 Indianapolis Road, New Carrollton, MD.

29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	29c. License number H0053827	29d. Date signed (Month, Day, Year) February 23, 2012
29b. Signature and title of certifier <i>Salvador Sylvester</i>		

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Salvador Sylvester 3001 Hospital Drive, Cheverly, Maryland</i>	31. Date filed (Month, Day, Year) FEB 27 2012	32. Registrar's Signature <i>Laura P. Park</i>
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Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

BAL +1

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07819

1- For
State
Registrar

Physician/
Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Maureen A. Gantz

2. Date of Death

Month Day Year
February 19, 2012

3. Time of Death

9:15 AM

Funeral
Director

4a. Facility Name (if not institution, give street and number)

12834 Holiday Lane

4b. City, Town, or Location of Death

Bowie

4c. County of Death

Prince George's

5. Social Security Number

494-34-3455

6. Sex

1 M 2 F

7. Age (In yrs. last birthday)

78

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)

July 25, 1933

9. Birthplace (State or Foreign Country)

Missouri

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Bowie

10d. Inside City Limits

Yes 2 No

10e. Street and Number

12834 Holiday Lane

10f. Zip Code

20715

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
10

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

homemaker own home

17. Father's Name (First, Middle, Last)

Louis Rifkin

18. Mother's Name (First, Middle, Maiden Surname)

Anne Ladensky

19a. Informant's Name/Relationship (Type, Print)

Roberta S. Krockett-daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1132 Knightwood Road, Diggs, Virginia 23045

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Md Veterans Cemetery

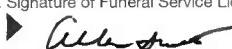
Date

2/22/2012

20c. Location - City or Town, State

Crownsville, Md.

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Robert E. Evans Funeral Home

16000 Annapolis Road, Bowie, Md. 20715

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit medical certificate.

Medical Certificate: To Be Completed by Physician/Medical Examiner

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death

Chronic obstructive pulmonary disease 5 1/2 years

a. Due to (or as a consequence of):

Aort. c stenosis

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No
9 Unknown

23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify)
9 Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Parkinson's disease

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

25. Was case referred to medical examiner?

1 Yes 2 No

26. Place of Death (Check only one)

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 5 Pending Investigation
2 Accident 6 Could not be determined
3 Suicide
4 Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
only one 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

R112087

29d. Date signed (Month, Day, Year)

2/20/12

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Janet M. Boeke 149919 Health Center Dr. # 201 Bowie, MD 20716

31. Date filed (Month, Day, Year)

FEB 22 2012

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07820

1 - For
State
RegistrarPhysician/
Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last) LAWRENCE A. GRIGSBY		2. Date of Death Month 02 Day 17 Year 2012		3. Time of Death 1147 AM
4a. Facility Name (if not institution, give street and number) Mandrin Inpatient Care Center		4b. City, Town, or Location of Death Harwood		4c. County of Death Anne Arundel
5. Social Security Number 227-18-9686		6. Sex 1 X M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5/27/1921
Usual Residence of Decedent Maryland Anne Arundel		10a. State Maryland		10b. County Anne Arundel
10c. City, Town or Location Harwood		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 X No		
10e. Street and Number 802 Richardson Drive		10f. Zip Code 20776		10g. Citizen of What Country? USA
11. Marital Status 1 <input type="checkbox"/> Never Married 2 X Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates. WWII	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 <input type="checkbox"/> Yes 2 X No Specify:	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Manager		16b. Kind of Business/Industry Bakery
17. Father's Name (First, Middle, Last) Cauley Grigsby		18. Mother's Name (First, Middle, Maiden Surname) Florence Rolley		
19a. Informant's Name/Relationship (Type, Print) Florence G. Bozzella/Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 802 Richardson Drive, Harwood, MD 20776		
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 X Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Kalas Crematory	Date 2/19/2012	20c. Location - City or Town, State Edgewater, Maryland
21. Signature of Funeral Service Licensee George P. Kalas		22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, Md. 21037		
<p>23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.</p> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. Due to (or as a consequence of): Pneumonia</p> <p>b. Due to (or as a consequence of): probable brainstem stroke</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p> <p>Approximate Interval Between Onset and Death 1 week</p> <p>Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p>				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
<p>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</p> <p>CAD Dementia</p> <p>23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</p>				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) hospt		23f. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Unknown
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year) M	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) At home		28d. Describe how injury occurred
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number 058756		29d. Date signed (Month, Day, Year) 2/17/2012
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Merlyn A. Purrott 445 Defense Hwy Annapolis MD 21401				
31. Date filed (Month, Day, Year) FEB 22 2012		32. Registrar's Signature Anna J. Parks		

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07821

1- For
State
RegistrarPhysician/
Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit: Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/
Medical
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit

		1. Decedent's Name (First, Middle, Last)			2. Date of Death		3. Time of Death	
		Milton Bourne Howes			Month February Day 22, 2012 Year		9:20 A. M.	
Physician/ Medical Examiner		4a. Facility Name (if not institution, give street and number)			4b. City, Town, or Location of Death		4c. County of Death	
		Calvert Memorial Hospital			Prince Frederick		Calvert	
Funeral Director		5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign Country)
		217-36-6096	1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	88 Yrs.	Months	Days	(Month Day Year) 08/25/1923	Maryland
To Be Completed by Funeral Director		Usual Residence of Decedent			10a. State MD 10b. County Calvert 10c. City, Town or Location Owings			10d. Inside City Limits <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
		10e. Street and Number 8210 Bourne Road			10f. Zip Code 20736		10g. Citizen of What Country? U.S.A.	
Physician/ Medical Examiner		11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: white			
		15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) 5	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) farming	16b. Kind of Business Industry agriculture				
To Be Completed by Physician/Medical Examiner		17. Father's Name (First, Middle, Last) James Milton Howes	18. Mother's Name (First, Middle, Maiden Surname) Grace Bourne					
		19a. Informant's Name/Relationship (Type, Print) Laurie A. Coleman, companion	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8210 Bourne Road, Owings, MD 20736					
Physician/ Medical Examiner		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) All Saints Cemetery	Date 02/25/2012	20c. Location - City or Town, State Sunderland, MD			
		21. Signature of Funeral Service Licensee 	22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 20736					
Medical Certificate: To Be Completed by Physician/Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consequence of): Aspiration Pneumonia b. Due to (or as a consequence of): Cerebrovascular Accident c. Due to (or as a consequence of): d. Due to (or as a consequence of):			Approximate Interval between Onset and Death 5 Days 5 Days		
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year				
Medical Certificate: To Be Completed by Physician/Medical Examiner		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Anoxic Encephalopathy Ischemic Cardiomyopathy			23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA	Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
Medical Certificate: To Be Completed by Physician/Medical Examiner		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide	28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
Medical Certificate: To Be Completed by Physician/Medical Examiner		29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	29c. License number D0052401			29d. Date signed (Month, Day, Year) February 22, 2012		
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas Annulis, MD, 100 Hospital Road, Prince Frederick, MD 20678						
Medical Certificate: To Be Completed by Physician/Medical Examiner		31. Date filed (Month, Day, Year) FEB 24 2012	32. Registrar's Signature 					

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07822

1- For State Registrar**Physician/
Medical Examiner**

1. Decedent's Name (First, Middle, Last) Tina Hillegas	2. Date of Death Month Day Year February 18, 2012	3. Time of Death 1137 hrs
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Funeral Director

4a. Facility Name (if not institution, give street and number) 1971 Richard Lane	4b. City, Town, or Location of Death Lusby	4c. County of Death Calvert
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To Be Completed by Funeral Director

5. Social Security Number 212-68-3392	6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 48	If Under 1 Year Months Days Hours Min. Yrs.	8. Date of Birth (MM/DD/YYYY) 09/06/1963	9. Birthplace (State or Foreign Country) MD
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Usual Residence of Decedent 10a. State MD	10b. County Calvert	10c. City, Town or Location Lusby	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
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10e. Street and Number 1971 Richard Lane	10f. Zip Code 20657	10g. Citizen of What Country? United States
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11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: Specify: White	14. Race - American Indian, Black, White, etc.
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15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+	16b. Kind of Business/Industry Auditor Dept. of Defense	U. S. Government
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17. Father's Name (First, Middle, Last) James Herbert Catterton, Jr.	18. Mother's Name (First, Middle, Maiden Surname) Jean Viola Richards
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19a. Informant's Name/Relationship (Type, Print) Daniel J. Hillegas - Husband	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1971 Richard Lane, Lusby, Maryland 20657
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20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:	20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory	Date 02/22/12	20c. Location - City or Town, State Alexandria, Virginia
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21. Signature of Funeral Service Licensee S. S. Smith	22. Name and Address of Facility Rausch Funeral Home, P. A.
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P. O. Box 600, Lusby, Maryland 20657**Baltimore, MD 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

**Physician/
Medical Examiner****Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and Death
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Immediate Cause (Final disease or condition resulting in death)	a. Gunshot Wound of Head Due to (or as a consequence of):
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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):
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c. Due to (or as a consequence of):	d. Due to (or as a consequence of):
-------------------------------------	-------------------------------------

<input type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED	
--	--

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
--	--

	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
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25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA	26. Place of Death (Check only one) Other 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene
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27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input checked="" type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day, Year) FOUND: Feb 18, 2012	28b. Time of Injury 1136 hrs	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	28d. Describe how injury occurred Subject shot self
--	--	--	---	---

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Single Family Home	28f. Location (Street and Number or Rural Route Number, City or Town, State) 1971 Richard Lane, Lusby, MD
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29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) February 19, 2012
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30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

31. Date filed (Month, Day, Year) FEB 23 2012	32. Registrar's Signature Denise S. Parker
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drw 15
State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07823

1 - For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last)							2. Date of Death		3. Time of Death															
	Mary Elizabeth Hamilton							Month	Day	Year	4.6. County of Death														
Funeral Director	4a. Facility Name (if not institution, give street and number)			4b. City, Town, or Location of Death				5. Social Security Number			6. Sex		7. Age (In yrs. last birthday)		If Under 1 Year		If Under 24 Hrs.		8. Date of Birth (Month, Day, Year)		9. Birthplace (State or Foreign Country)				
	Civista Medical Center			La Plata				577-38-9205			<input type="checkbox"/> M <input checked="" type="checkbox"/> F		80 Yrs.		Months		Days		Hours		Min.		03-29-1931		Washington, D.C.
To Be Completed by Funeral Director	10a. State		10b. County		10c. City, Town or Location				10d. Inside City Limits		10e. Street and Number		10f. Zip Code				10g. Citizen of What Country?								
	Maryland		Charles		Charlotte Hall				<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		9685 Old Sycamore Rd.		20622				U S A								
To Be Completed by Physician/Medical Examiner	11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?				13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)				14. Race - American Indian, Black, White, etc.														
	1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:				1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				Specify: White														
Medical Certificate: To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)				16b. Kind of Business/Industry																		
	Elementary/Secondary (0-12) 9		College (1-4 or 5+) Cashier				Grocery																		
Division of Vital Records, P.O. Box 68760	17. Father's Name (First, Middle, Last)							18. Mother's Name (First, Middle, Maiden Surname)																	
	Frank Dryden Dawson							Lena Mary Depharini																	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.	19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)																						
	Betty J. Murphy/daughter		27053 Holly Lane, Mechanicsville, MD 20659																						
Physician/ Medical Examiner	20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)				Date		20c. Location - City or Town, State																
	1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) Brinsfield-Echols Crem.		2/24/2012				Charlotte Hall, MD																		
Medical Certificate: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee		22. Name and Address of Facility																						
	Larry C. Echols M00817		Brinsfield-Echols F.H., P.A. 30195 Three Notch Rd., Charlotte Hall, MD 20622																						
Physician/ Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death												
	Immediate Cause (Final disease or condition resulting in death)												91 days												
Medical Certificate: To Be Completed by Physician/Medical Examiner	23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown												23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year										
	24. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No												24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No												
Medical Certificate: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one)				23e. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown																		
	Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																						
Medical Certificate: To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred																
	3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)																				
Medical Certificate: To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number D46419										29d. Date signed (Month, Day, Year) 2/22/12												
	29b. Signature and title of certifier ►		29c. License number D46419										29d. Date signed (Month, Day, Year) 2/22/12												
Medical Certificate: To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)												31. Date filed (Month, Day, Year) FEB 27 2012		32. Registrar's Signature Suzanne A. Farrel										

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07824

1- For
State
Registrar

Physician/
Medical
Examiner

Baltimore, Maryland 21215-0036
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) Evelyn Alice Hull			2. Date of Death Month 2 Day 21 Year 2012	3. Time of Death 8:00 pm^M
4a. Facility Name (if not institution, give street and number) Crofton Convalescent Care & Rehab			4b. City, Town, or Location of Death Crofton	
4c. County of Death Anne Arundel				
5. Social Security Number 213-46-4784		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days Hours Min.
8. Date of Birth (Month, Day, Year) 5/29/1926		9. Birthplace (State or Foreign Country) MD		
10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Annapolis
10d. Inside City Limits 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
10e. Street and Number 2596 Timber Cove			10f. Zip Code 21401	10g. Citizen of What Country? USA
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
14. Race - American Indian, Black, White, etc. White				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Homemaker		16b. Kind of Business/Industry Own Home
17. Father's Name (First, Middle, Last) Peter S. Macaulay			18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Galloway	
19a. Informant's Name/Relationship (Type, Print) Penny Warren daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2596 Timber Cove Annapolis, MD 21401		
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Atlantic Crematory		Date 2/23/2012
20c. Location - City or Town, State Glen Burnie, MD				
21. Signature of Funeral Service Licensee Cynthia Reimbold		22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401		

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Dementia			Approximate Interval Between Onset and Death 6 years	
b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) g <input type="checkbox"/> Unknown		
		23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Urinary Tract Infection			23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) At home		28d. Describe how injury occurred
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number D0029571		
29b. Signature and title of certifier Paul Berez MD		29d. Date signed (Month, Day, Year) 2/22/2012		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Paul Berez 2200 Defense Hwy Ste 103 Crofton, MD 21114				
31. Date filed (Month, Day, Year) FEB 24 2012		32. Registrar's Signature Paul A. Berez		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 17825

For
State
Registrar

Physician/
Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

1. Decedent's Name (First, Middle, Last) Rosa L. Hayes			2. Date of Death Month Feb.	3. Time of Death Day 17 Year 2012 9:50 P M
4a. Facility Name (if not institution, give street and number) Forestville Health&Rehab.Center			4b. City, Town, or Location of Death Forestville	
5. Social Security Number 225 60 4680			6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.
			If Under 1 Year Months	If Under 24 Hrs. Hours Min.
			8. Date of Birth (Month, Day, Year) 4/18/1928	9. Birthplace (State or Foreign Country) VA
Usual Residence of Decedent 10a. State MD 10b. County Prince George's 10c. City, Town or Location Forestville			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 7420 Marlboro Pike			10f. Zip Code 20747	10g. Citizen of What Country? USA
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) 6		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer		16b. Kind of Business Industry Domestic/Private
17. Father's Name (First, Middle, Last) Daniel Hayes Jr.			18. Mother's Name (First, Middle, Maiden Surname) Lessie Jackson	
19a. Informant's Name/Relationship (Type, Print) Sherman Hayes/ Son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 306 Monroe Circle Colonial Beach, VA 22443	
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Historyland Cem.	Date 2/25/12
21. Signature of Funeral Service Licensee Kimberly Burstone			20c. Location - City or Town, State King George, VA	
21. Signature of Funeral Service Licensee Kimberly Burstone			22. Name and Address of Facility Weldon Fisher Funeral Home 22883 Kings Hwy. Warsaw, VA 22572	

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Dementia		Approximate Interval Between Onset and Death			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CVA					
a. Due to (or as a consequence of): Hypertension					
b. Due to (or as a consequence of): Diabetes					
c. Due to (or as a consequence of):					
d. Due to (or as a consequence of):					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number D0070693		29d. Date signed (Month, Day, Year) 02-22-2012	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STED MATBOOB		6934 Aviation Blvd Suite B Glen Burnie, MD 21061			
31. Date filed (Month, Day, Year) FEB 27 2012		32. Registrar's Signature Anna S. Parker			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

1 - For
State
Registrar

Certificate of Death

Reg. No.

2012 07826

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) JEREMIAH B. HAWKINS				2. Date of Death Month 16 Year 2012	3. Time of Death Hour 06 M		
	4a. Facility Name (if not institution, give street and number) 7103 Sheffield Drive		4b. City, Town, or Location of Death Temple Hills		4c. County of Death Prince George's			
Funeral Director	5. Social Security Number 214-24-8617	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Dec 21 1929	9. Birthplace (State or Foreign Country) Maryland	
To Be Completed by Funeral Director	10a. State Maryland		10b. County Prince George's	10c. City, Town or Location Temple Hills			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 7103 Sheffield Drive			10f. Zip Code 20748		10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates 1952-75		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 4yrs Army Aviator		16b. Kind of Business/Industry United States Army			
	17. Father's Name (First, Middle, Last) Lawrence Hawkins			18. Mother's Name (First, Middle, Maiden Surname) Francis Hall				
	19a. Informant's Name/Relationship (Type, Print) Anna Hawkins (Wife)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7103 Sheffield Drive Temple Hills, Md. 20748				
Physician/ Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington National		Date 3-21-12	20c. Location - City or Town, State Arlington, Va		
Medical Certificate: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Larry G. Reese		22. Name and address of Facility Reese & Sons Mortuary, P.A. 1922 Forest Dr. Annapolis, Md. 21401					
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) LUNG CANCER						Approximate Interval Between Onset and Death MONTHS	
	23b. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	23c. Due to (or as a consequence of): LUNG CANCER							
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07827

1- For
State
RegistrarPhysician/
Medical
Examiner

Permit: Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

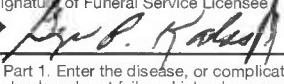
Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

Funeral
Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) ROBERTA B. HART		2. Date of Death Month / Day / Year 12 / 16 / 12 10:13 AM		3. Time of Death 10:13 AM
4a. Facility Name (if not institution, give street and number) 56 Regatta Bay Court #124		4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arundel
5. Social Security Number 074-22-6158		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days Hours Min.
Usual Residence of Decedent Maryland Anne Arundel		8. Date of Birth (Month, Day, Year) 10/13/1927		
10a. State Maryland		10b. County Anne Arundel	10c. City, Town or Location Annapolis	
10e. Street and Number 56 Regatta Bay Court #124		10f. Zip Code 21401		10g. Citizen of What Country? USA
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mother		16b. Kind of Business/Industry Own Home and Children
17. Father's Name (First, Middle, Last) James Robert Britton		18. Mother's Name (First, Middle, Maiden Surname) Jeanette Eugenia Clark		
19a. Informant's Name/Relationship (Type, Print) Michael W. Hart/Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1801 Crosspointe Dr., Annapolis, MD 21401		
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Kalas Crematory		20b. Place of Disposition (Name of cemetery, crematory or other place) Kalas Crematory	Date 2/17/2012	20c. Location - City or Town, State Edgewater, Maryland
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037		
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) { a. Due to (or as a consequence of): Carcinoma of the appendix b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death (6 years)				
23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (Specify) _____		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____		
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year) M	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred _____
28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. Signature and title of certifier 		29c. License number DT2254		29d. Date signed (Month, Day, Year) 2/17/2012
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maria A. Perrone MD 845 Defense Hwy Annapolis MD 21401				
31. Date filed (Month Day Year) FEB 22 2012		32. Registrar's Signature 		

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036
 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial permit.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #10g Per FH G926 4/27/2012 Jh
 State of Maryland / Department of Health and Mental Hygiene
 AMEND ITEM#30 per PHYS, G926, 4/27/2012, WS
Certificate of Death

Reg. No. **2012 07828**

1 - For State Registrar

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) Ivan Pavlov Ianchovichin		2. Date of Death Month February Day 21 , Year 2012		3. Time of Death 3:07 PM		
Funeral Director		4a. Facility Name (if not institution, give street and number) 5806 Maiden Lane		4b. City, Town, or Location of Death Bethesda		4c. County of Death Montgomery		
To Be Completed by Funeral Director		5. Social Security Number none	6. Sex 1 X M 2 F	7. Age (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months 	If Under 24 Hrs. Hours 	8. Date of Birth (Month, Day, Year) July 8, 1929	9. Birthplace (State or Foreign Country) Bulgaria
		Usual Residence of Decedent						10d. Inside City Limits 1 X Yes 2 No
		10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Bethesda		
		10e. Street and Number 5806 Maiden Lane		10f. Zip Code 20817		10g. Citizen of What Country? Bulgaria United States		
		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Caucasian
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Teacher/Principal		16b. Kind of Business/Industry Education		
		17. Father's Name (First, Middle, Last) Pavel Ianchovichin		18. Mother's Name (First, Middle, Maiden Surname) Elena Nikolova Zaikova				
		19a. Informant's Name/Relationship (Type, Print) Liliana Ianchovichina, Spouse		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5806 Maiden Lane, Bethesda, Maryland 20817				
		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) Fort Lincoln Crematory		20b. Place of Disposition (Name of cemetery, crematory or other place) Feb. 24, 2012		Date Brentwood, Maryland	20c. Location - City or Town, State	
		21. Signature of Funeral Service Licensee Ann Rowe		M01102		22. Name and Address of Facility Simple Tribute	1040 Rockville Pike, Rockville, Maryland 20852	
Physician/ Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) { a. Alzheimers disease Due to (or as a consequence of): CHRONIC DISK DISEASE b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death: 3 yrs						
		23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown 23d. Date of delivery Month Day Year 						
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						
		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown						
		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
		26. Place of Death (Check only one) 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide 28a. Date of injury (Month, Day, Year) 28b. Time of injury M 28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)						
		29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
		29b. Signature and title of certifier J. Hellman 29c. License number D 20674 29d. Date signed (Month, Day, Year) FEBRUARY 22, 2012						
		30. Name and address of person who completed cause of death item 23a) (Type, Print) Dr. Hellman, 6240 Montrose Road, Rockville, Maryland 20852						
		31. Date filed (Month, Day, Year) FEB 27 2012 32. Registrar's Signature J. Hellman						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07829

1 - For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) BILLY ANDREW JACKSON					2. Date of Death Month Day Year FEBRUARY 21, 2012	3. Time of Death 2:16P M
	4a. Facility Name (if not institution, give street and number) FREDERICK MEMORIAL HOSPITAL			4b. City, Town, or Location of Death FREDERICK		4c. County of Death FREDERICK	
Funeral Director	5. Social Security Number 415-38-1043	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (in yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days Hours Min. 8. Date of Birth Month Day Year 03/05/1928	9. Birthplace (State or Foreign Country) TN		
	10a. State MD			10b. County Frederick			10c. City, Town or Location New Market
To Be Completed by Funeral Director	10e. Street and Number 6651 Coldstream Dr.			10f. Zip Code 21774		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates. 1948-50		13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White		14. Race - American Indian, Black, White, etc. Specify: White
Physician/ Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) division manager			16b. Kind of Business Industry convience store
	17. Father's Name (First, Middle, Last) William Andrew Jackson			18. Mother's Name (First, Middle, Maiden Surname) Tennessee Trula Norris			
Medical Certificate: To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Doris Jackson/wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6651 Coldstream Dr., New Market, MD 21774			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Garrison Forest VA		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date 02/29/2012	20c. Location - City or Town, State Baltimore, MD	
21. Signature of Funeral Service Licensee Cathy G. Me			22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 21702				
23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Immediate Cause (Final disease or condition resulting in death)			Approximate Interval Between Onset and Death Years				
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			<p>a. Due to (or as a consequence of): Atherosclerotic Cardiovascular Disease</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. _____</p>				
IF FEMALE:		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes mellitus Hypertension						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			23f. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
27. Manner of death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Pending <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
			M				
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier Alan Rohrer, MD			29c. License number D37197			29d. Date signed (Month, Day, Year) 2/21/2012	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alan Rohrer, MD 15 West 7th Street Frederick, MD 21701							
31. Date filed (Month, Day, Year) FEB 27 2012		32. Registrar's Signature James A. Park					

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

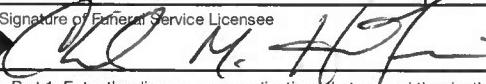
2012 07830

1 - For
State
RegistrarPhysician/
Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last) AGNES MARIE JEWELL			2. Date of Death Month Day Year FEBRUARY 23, 2012			3. Time of Death 6:45 PM		
4a. Facility Name (if not institution, give street and number) CORSICA HILLS NURSING HOME			4b. City, Town, or Location of Death CENTREVILLE			4c. County of Death QUEEN ANNE'S		
5. Social Security Number 157-01-2123		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 98 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) MARCH 13, 1913	9. Birthplace (State or Foreign Country) MARYLAND	
Usual Residence of Decedent 10a. State MD 10b. County QUEEN ANNE'S 10c. City, Town or Location CENTREVILLE 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
10e. Street and Number 812 CHURCH HILL ROAD			10f. Zip Code 21617			10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: WHITE			14. Race - American Indian, Black, White, etc. Specify:	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) -0-		16b. Kind of Business Industry HOMEMAKER			16c. Kind of Business Industry OWN HOME	
17. Father's Name (First, Middle, Last) OLIE FORD				18. Mother's Name (First, Middle, Maiden Surname) BESSIE STRADLEY				
19a. Informant's Name/Relationship (Type, Print) JOAN PINDER/ DAUGHTER			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 212 HOPE ROAD, CENTREVILLE, MARYLAND 21617					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) CHESTERFIELD CEMETERY			Date FEB. 27, 2012	20c. Location - City or Town, State CENTREVILLE, MD	
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWMAN FUNERAL HOME, P.A. 408 S. LIBERTY ST., CENTREVILLE, MD 21617					

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

DHMH 17 Rev 7/2009

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		<i>Adult failure to thrive</i>			Approximate Interval Between Onset and Death <i>months</i>
		Due to (or as a consequence of): <i>Dementia</i>			<i>years</i>
		Due to (or as a consequence of): <i>cardiovascular insufficiency</i>			<i>years</i>
		Due to (or as a consequence of): <i>Hypertension</i>			<i>years</i>
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 			
		29c. License number DZS953			29d. Date signed (Month, Day, Year) 2-27-2012
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD Crowley, MD 610 Duldimans Lane, Easton, MD 21601					
31. Date filed (Month, Day, Year) FEB 28 2012		32. Registrar's Signature 			

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2012 07831

Certificate of Death

Reg. No.

1- For
State
Registrar**Physician/
Medical
Examiner**

Baltimore, Maryland 21215-0036
 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland
 Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
 any injury or other traumatic event, the Medical Examiner must be notified at
 once.

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed
 within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and
 completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland
 Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
 any injury or other traumatic event, the Medical Examiner must be notified at
 once.

**Funeral
Director**

1. Decedent's Name (First, Middle, Last) Teresa R. Johnson			2. Date of Death Month February Day 11 Year 2012	3. Time of Death 1833 M
4a. Facility Name (if not institution, give street and number) 1 Womack Drive			4b. City, Town, or Location of Death Annapolis	
4c. County of Death Anne Arundel				
5. Social Security Number 579-98-9715		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 38 Yrs.	If Under 1 Year Months Days Hours Min.
Usual Residence of Decedent Maryland Anne Arundel				
10a. State Maryland		10b. County Anne Arundel	10c. City, Town or Location Annapolis	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
10e. Street and Number 419 A Captain's Circle			10f. Zip Code 21401	10g. Citizen of What Country? USA
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 0	16b. Kind of Business/Industry District Court of Maryland
17. Father's Name (First, Middle, Last) James H. West			18. Mother's Name (First, Middle, Maiden Surname) Yvonne S. Coates	
19a. Informant's Name/Relationship (Type, Print) Jay J. Johnson (Husband)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 419 A Captain's Circle Annapolis, Md. 21401	
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Metro Crematory			20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory	Date 2-20-12
21. Signature of Funeral Service Licensee Larry S. Reese			20c. Location - City or Town, State Wm. Reese & Sons Mortuary, P.A. 1922 Forest Dr. Annapolis, Md. 21401	
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)			Approximate Interval Between Onset and Death Cardiac Arrest	
<p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> <p>{</p> <p>a. Due to (or as a consequence of): Cardiomyopathy</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. _____</p>				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input checked="" type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown		
23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) HOTEL		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number 50969		
		29d. Date signed (Month, Day, Year) 02/16/12		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rulent R. Zaim				
31. Date filed (Month, Day, Year) FEB 22 2012		32. Registrar's Signature Teresa R. Johnson		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2012 07832

Certificate of Death

Reg. No.

1 - For
State
Registrar

AMEND#19aperFH, 2/29/12; FMW, MoCo

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Marian K. Kuperberg						2. Date of Death Month February Day 22 , Year 2012	3. Time of Death 9:21 P M		
	4a. Facility Name (if not institution, give street and number) Suburban Hospital			4b. City, Town, or Location of Death Bethesda			4c. County of Death Montgomery			
Funeral Director	5. Social Security Number 189-18-0865		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) 11/06/1924	9. Birthplace (State or Foreign Country) Pennsylvania		
	Usual Residence of Decedent MD		10a. State Montgomery		10c. City, Town or Location Bethesda			10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number 5225 Pooks Hill Road, Apt. 709N				10f. Zip Code 20814		10g. Citizen of What Country? United States			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. White Specify:		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home			
	17. Father's Name (First, Middle, Last) Harry Kliger				18. Mother's Name (First, Middle, Maiden Surname) Pauline Simon					
	19a. Informant's Name/Relationship (Type, Print) Kenneth Marks-Son -In-Law				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10009 Bentcross Drive Potomac, MD 20854					
Physician/ Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) King David Mem Gdns		Date 02/24/2012	20c. Location - City or Town, State Falls Church, Virginia			
Medical Certificate: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee MO163				22. Name and Address of Facility Edward Sage Funeral Direction, Inc 1091 Rockville Pike Rockville, MD 20852					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Acute Myelogenous Leukemia								Approximate Interval Between Onset and Death	
	<p>a. Due to (or as a consequence of): Acute Myelogenous Leukemia</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred				
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	29b. Signature and title of certifier J. Morton				29c. License number 62234		29d. Date signed (Month, Day, Year) February 22, 2012			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James Morton, MD 8600 Old Georgetown Road Bethesda, MD 20814									
State Registrar	31. Date filed (Month, Day, Year) FEB 27 2012		32. Registrar's Signature James J. Morton							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2012 07833

1- For
State
Registrar
AMEND#5perFH, 2/27/12; EMW, MoCo

Reg. No.

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) Mary Ann Kirlin						2. Date of Death Month February Day 22 , Year 2012	3. Time of Death 6:08 A M			
Funeral Director		4a. Facility Name (if not institution, give street and number) 6417 Kennedy Street			4b. City, Town, or Location of Death Chevy Chase			4c. County of Death Montgomery				
To Be Completed by Funeral Director		5. Social Security Number 579-40-4367	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) 12/07/1930	9. Birthplace (State or Foreign Country) New York				
To Be Completed by Funeral Director		10a. State FL	10b. County Palm Beach	10c. City, Town or Location Palm Beach			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
To Be Completed by Physician/Medical Examiner		10e. Street and Number 153 Clarke Avenue			10f. Zip Code 33480			10g. Citizen of What Country? United States				
To Be Completed by Physician/Medical Examiner		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc.					
To Be Completed by Physician/Medical Examiner		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home				
To Be Completed by Physician/Medical Examiner		17. Father's Name (First, Middle, Last) Frederick Gerard Kerr			18. Mother's Name (First, Middle, Maiden Surname) Laurette Dumphy							
To Be Completed by Physician/Medical Examiner		19a. Informant's Name/Relationship (Type, Print) Timothy J. Kirlin / Son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7508 Arrowood Rd. Bethesda, MD 20817							
To Be Completed by Physician/Medical Examiner		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Gate of Heaven Cemetery			20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery			Date 02/27/2012	20c. Location - City or Town, State Silver Spring, MD			
To Be Completed by Physician/Medical Examiner		21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Joseph Gawler's Sons Inc. 5130 Wisconsin Ave. NW Washington, DC 20016							
To Be Completed by Physician/Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									Approximate Interval Between Onset and Death	
To Be Completed by Physician/Medical Examiner		<p>a. Due to (or as a consequence of): Metastatic Lung Cancer</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. _____</p>										
To Be Completed by Physician/Medical Examiner		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year					
To Be Completed by Physician/Medical Examiner		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner											23f. Did alcohol contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Alternate Residence								
To Be Completed by Physician/Medical Examiner		27. Manner of Death 1 Natural <input type="checkbox"/> Pending Investigation 2 Accident <input type="checkbox"/> Could not be determined 3 Suicide 4 Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work? M <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred					
To Be Completed by Physician/Medical Examiner				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)					
To Be Completed by Physician/Medical Examiner		29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number D26259			29d. Date signed (Month, Day, Year) 2/23/2012					
To Be Completed by Physician/Medical Examiner		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ava A. Kaufman MD 8218 Wisconsin Ave. Suite 103 Bethesda, MD 20814										
State Registrar		31. Date filed (Month, Day, Year) FEB 27 2012		32. Registrar's Signature 								

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial slip.

18

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

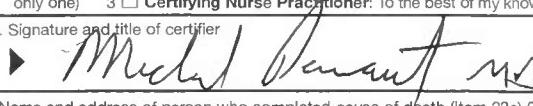
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07834

1 - For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Charles Dewitt Kirby						2. Date of Death Month Day Year February 26, 2012	3. Time of Death M 2336
	4a. Facility Name (if not institution, give street and number) St. Mary's Hospital			4b. City, Town, or Location of Death Leonardtown			4c. County of Death St. Mary's	
Funeral Director	5. Social Security Number 262-90-7997 Usual Residence of Decedent		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 62 Yrs.	If Under 1 Year Months Days Hours Min.	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 10/25/1949	9. Birthplace (State or Foreign Country) Michigan
	10a. State South Carolina	10b. County Horry	10c. City, Town or Location Myrtle Beach					10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
To Be Completed by Funeral Director	10e. Street and Number 103 Dorman Circle			10f. Zip Code 29577			10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Commissary Manager			16b. Kind of Business/Industry U.S. Government	
	17. Father's Name (First, Middle, Last) William Kirby			18. Mother's Name (First, Middle, Maiden Surname) Viola Williams				
	19a. Informant's Name/Relationship (Type, Print) Vera L. Jarrett/ Significant Other			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 103 Dorman Circle Myrtle Beach, SC 29577				
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of Cemetery, crematory or other place) Mattingley-Gardiner Funeral Home, P.A. Crematory			Date 02/28/2012	20c. Location - City or Town, State Leonardtown, MD
	21. Signature of Funeral Service licensee 			22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A., 41590 Fenwick St., Leonardtown, MD 20650				
Physician/ Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)			Cardiac Dysrhythmia			Approximate Interval Between Onset and Death Minutes	
	a. Due to (or as a consequence of):							
	b. Due to (or as a consequence of):			Gastrointestinal Hemorrhage			Days	
	c. Due to (or as a consequence of):			Pancreatic Cancer			Months	
	d. _____							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
Medical Certificate: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number D0068427			29d. Date signed (Month, Day, Year) February 27, 2012		
	29b. Signature and title of certifier 							
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael E. Perraut, 25500 Point Lookout Rd., Leonardtown, MD 20650							
State Registrar	31. Date filed (Month, Day, Year) MAR 01 2012		32. Registrar's Signature 					

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Gene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07835

1- For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) MARY LOUISE LEAGER							2. Date of Death Month Day Year FEBRUARY 23, 2012	3. Time of Death 11:10 PM
	4a. Facility Name (if not institution, give street and number) QUEEN ANNE'S COUNTY HOSPICE CENTER				4b. City, Town, or Location of Death CENTREVILLE			4c. County of Death QUEEN ANNE'S	
Funeral Director	5. Social Security Number 217-14-8271	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 93 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) JULY 31, 1918	9. Birthplace (State or Foreign Country) MARYLAND		
	Usual Residence of Decedent MD QUEEN ANNE'S CHURCH HILL				10c. City, Town or Location CHURCH HILL			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10a. State MD				10b. County QUEEN ANNE'S			10f. Zip Code 21623		
10e. Street and Number 529 LIEBY ROAD				10g. Citizen of What Country? USA					
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: WHITE			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER			16b. Kind of Business/Industry OWN HOME			
17. Father's Name (First, Middle, Last) FREDERICK WRIGHT					18. Mother's Name (First, Middle, Maiden Surname) EMMA HIGNUT				
19a. Informant's Name/Relationship (Type, Print) MARGARET ANN GRETZINGER/DAUGHTER					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 101 SCHOOL ROAD, CHESTERTOWN, MD 21620				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) SUDLERSVILLE CEMETERY			Date FEB. 28, 2012	20c. Location - City or Town, State SUDLERSVILLE, MD		
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWMAN FUNERAL HOME, P.A. 408 S. LIBERTY ST., CENTREVILLE, MD 21617						
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Arteriosclerosis									
Approximate Interval Between Onset and Death years									
23b. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Arteriosclerosis									
23c. If female: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year						
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			23f. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
23g. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			23h. Describe how injury occurred						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) HOSPICE CENTER						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29c. License number D16488			29d. Date signed (Month, Day, Year) 2/24/12			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wayne D Benjamin, M.D.			32. Registrar's Signature Patricia S. Park						
31. Date filed (Month, Day, Year) FEB 27 2012		32. Registrar's Signature							

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Physician/
Medical
Examiner

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07836

1 - For
State
Registrar

Physician/
Medical
Examiner

Baltimore, Maryland 21215-0036
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
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Physician/
Medical
Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed
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To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) <i>Robert G. Leginus</i>		2. Date of Death Month Day Year <i>February 20, 2012</i>		3. Time of Death <i>12:20 pm</i>
4a. Facility Name (if not institution, give street and number) <i>Gilchrist Hospice</i>		4b. City, Town, or Location of Death <i>Columbia</i>		4c. County of Death <i>Howard</i>
5. Social Security Number <i>211-10-0838</i>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>98 Yrs.</i>	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) <i>09/22/1913</i>
9. Usual Residence of Decedent <i>Maryland</i>		10. State <i>Maryland</i>		10b. County <i>Howard</i>
10c. City, Town or Location <i>Columbia</i>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <i>6389 Weather Wise Way</i>		10f. Zip Code <i>21045</i>		10g. Citizen of What Country? <i>U.S.A.</i>
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates. <i>WWII</i>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <i>Caucasian</i>	
15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Cartographer</i>		16b. Kind of Business/Industry <i>Federal Government</i>
17. Father's Name (First, Middle, Last) <i>Joseph Leginus</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>Katherine Panik</i>		
19a. Informant's Name/Relationship (Type, Print) <i>Adele Leginus - Spouse</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>6389 Weather Wise Way, Columbia, Maryland 21045</i>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>Gate of Heaven Cem.</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Gate of Heaven Cem.</i>		Date <i>02/25/2012</i>
21. Signature of Funeral Service Licensee <i>Sgt. Major MO 1894</i>		22. Name and Address of Facility <i>Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904</i>		
<p>23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.</p> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> <p><i>{</i></p> <p>a. <u>COMPLICATIONS OF DEMENTIA</u> Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p> <p>Approximate Interval Between Onset and Death <i>YEARS</i></p>				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
<p>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</p> <p>23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown</p> <p>24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <i>HOSPICE</i>		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No
		28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <i>D64395</i>		
29b. Signature and title of certifier <i>Danielle Doberman, MD</i>		29d. Date signed (Month, Day, Year) <i>FEBRUARY 20, 2012</i>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>DANIELLE DOBERMAN, MD 6334 CEDAR LANE COLUMBIA, MD 21044</i>				
31. Date filed (Month, Day, Year) <i>FEB 27 2012</i>		32. Registrar's Signature <i>Linda B. Parker</i>		

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07837

1 - For
State
RegistrarPhysician/
Medical
Examiner

1. Decedent's Name (First, Middle, Last)

CATHERINE C. LOGAN

2. Date of Death

Month
02Day
19Year
20123. Time of Death
10⁰⁰ P M

Baltimore, Maryland 21215-0036
 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland
 Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 28a or 28a-f show
 any injury or other traumatic event, the Medical Examiner must be notified at
 once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed
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 To the Funeral Director: After this certificate has been signed by the attending physician and
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Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician:

After this certificate has been signed by the attending physician and
 completely filled in by the funeral director, page 2 should be detached for use as the burial-transitState
Registrar

Medical Certificate: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) CATHERINE C. LOGAN				2. Date of Death Month 02 Day 19 Year 2012		3. Time of Death 10 ⁰⁰ P M					
Funeral Director		4a. Facility Name (if not institution, give street and number) Mandrin Inpatient Care Center		4b. City, Town, or Location of Death Harwood		4c. County of Death Anne Arundel							
		5. Social Security Number 213-48-7675	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 59 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 1/24/1953	9. Birthplace (State or Foreign Country) Virginia					
		10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Deale		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
		10e. Street and Number 962 Chesapeake Ave.			10f. Zip Code 20751			10g. Citizen of What Country? USA					
		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White				
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) School Nurse			16b. Kind of Business/Industry Health Care					
		17. Father's Name (First, Middle, Last) Morris Riker Hamilton				18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Lennon							
		19a. Informant's Name/Relationship (Type, Print) Patrick J. Logan/Husband			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 962 Chesapeake Ave. Deale, MD 20751								
		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>Kalas</i>			20b. Place of Disposition (Name of cemetery, crematory or other place) Kalas Crematory			Date 2/23/12	20c. Location - City or Town, State Edgewater, Maryland				
		21. Signature of Funeral Service Licensee <i>George P. Kalas</i>			22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037								
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Progressive hypoxic leukoencephalopathy								Approximate Interval Between Onset and Death 2 weeks			
		b. Due to (or as a consequence of): Complicating oxycotin intoxication								<i>2012-02-23 18:03:08 CERTIFICATION APPROVED BY STATE</i>			
		c. Due to (or as a consequence of):								<i>2012-02-23 18:03:08 CERTIFICATION APPROVED BY STATE</i>			
		d. _____								<i>2012-02-23 18:03:08 CERTIFICATION APPROVED BY STATE</i>			
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year						
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hepatitis B Hepatitis C 5-pdrm disease								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
		24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
		25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) Hospice			27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input checked="" type="checkbox"/> Suicide 7 <input type="checkbox"/> Injury to self 4 <input type="checkbox"/> Homicide			28a. Date of injury (Month, Day, Year) 1-2-2012	28b. Time of injury UNKNOWN	28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred TOOK TOO MUCH OXYCONTIN
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Own house		28f. Location (Street and Number or Rural Route Number, City or Town, State) 462 CHESAPEAKE AVENUE, DEALE, MD									
		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number PS2756			29d. Date signed (Month, Day, Year) 2/21/2012						
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Marion A. Ferrell 445 Defense Hwy Annapolis MD 21401											
		31. Date filed (Month, Day, Year) FEB 24 2012		32. Registrar's Signature <i>Marion A. Ferrell</i>									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2012 07838

1. For State Registrar**Physician/
Medical Examiner**

1. Decedent's Name (First, Middle, Last) Norma J. Lewnes	2. Date of Death Month Day Year February 20, 2012	3. Time of Death 0830 hrs
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Funeral Director

4a. Facility Name (if not institution, give street and number) Anne Arundel Medical Center	4b. City, Town, or Location of Death Annapolis	4c. County of Death Anne Arundel
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Baltimore, MD 21215-0036
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

5. Social Security Number 219-12-2735	6. Sex M	7. Age (in yrs. last birthday) 86	If Under 1 Year Months Yrs.	If Under 24 Hrs. Hours Min.	8. Date of Birth (MM/DD/YYYY) June 10, 1925	9. Birthplace (State or Foreign Country) Maryland
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10a. State Maryland	10b. County Anne Arundel	10c. City, Town or Location Annapolis	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
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10e. Street and Number 800 Bestgate Road	10f. Zip Code 21401	10g. Citizen of What Country? U.S.A.
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11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year of: 1960	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: White	14. Race - American Indian, Black, White, etc.
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15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Accounting Clerk	16b. Kind of Business/Industry Grocery
---	--	--

17. Father's Name (First, Middle, Last) Alonzo Hubbard	18. Mother's Name (First, Middle, Maiden Surname) Agnes Trew
--	--

19a. Informant's Name/Relationship (Type, Print) Keith Lewnes/son	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3763 Patuxent Crossover Davidsonville, MD 21035
---	---

20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify: Todd E. Tiller	20b. Place of Disposition (Name of cemetery, crematory or other place) Hillcrest Mem. Gardens	Date 2/25/2012	20c. Location - City or Town, State Annapolis, Maryland
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21. Signature of Funeral Service Licensee Todd E. Tiller	22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401
--	--

**Physician
Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Head and Neck Injuries Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. <input type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED	Approximate Interval Between Onset and Death
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IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
	24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No

25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other:	26. Place of Death (Check only one) 27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day, Year) FOUND: Feb 20, 2012	28b. Time of Injury 0730 hrs	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	28d. Describe how injury occurred Subject fell
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28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Assisted Living Facility	28f. Location (Street and Number or Rural Route Number, City or Town, State) 800 Bestgate Road, Annapolis, MD
---	---

29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) February 21, 2012
---	--	---

30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223
--

31. Date filed (Month, Day, Year) FEB 23 2012	32. Registrar's Signature Carole Allan
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Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For AMEND#10E 16A per FH
State
Registrar 2/22/2012 AACO HEALTH DEPT. CMH

Certificate of Death

Reg. No. 2012

07839

Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
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Division of Vital Records, P.O. Box 68760,

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Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Physician /Medical Examiner		Decedent's Name (First, Middle, Last) Gus W Leanos						Date of Death Month Feb Day 18 Year 2012		Time of Death 1058 A M	
		Facility Name (If not institution, give street and number) Anne Arundel Medical Center			City, Town, or Location of Death Annapolis			County of Death Anne Arundel			
		5. Social Security Number 216-18-5076	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth Month Day Year 8/28/1924	9. Birthplace (State or Foreign Country) Maryland			
		Usual Residence of Decedent 10a. State Maryland 10b. County Anne Arundel			10c. City, Town or Location Annapolis			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
		Street and Number 10e. Circle Unit 6 13 Silverwood Court			Zip Code 10f. 21403			Citizen of What Country? 10g. USA			
		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WW II			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			Race - American Indian, Black, White, etc. 14. White		
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Serviceman			16b. Kind of Business/Industry Telephone Company			
		17. Father's Name (First, Middle, Last) William Leanos			18. Mother's Name (First, Middle, Maiden Surname) Despina Annas						
		19a. Informant's Name/Relationship (Type, Print) Debbie Haynes - Daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 183 Hampshire Dr, Plainsboro, NJ 08536						
		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) St. Demetrios Cemetery			20b. Place of Disposition (Name of cemetery, crematory or other place) St. Demetrios Cemetery			Date 2/22/2012	20c. Location - City or Town, State Annapolis, MD		
		21. Signature of Funeral Service Licensee Myelin T. Hobart			22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St, Annapolis, MD 21401						
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)			23b. Due to (or as a consequence of): Pulmonary Edema			Approximate Interval Between Onset and Death			
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			23c. Due to (or as a consequence of): Congestive Heart Failure			5 yrs			
		{			23d. Due to (or as a consequence of): Chronic Renal Failure			5 yrs			
		23e. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ischemic Cardiomyopathy → Coronary Artery Disease Hypertension Atrial Fibrillation			23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown						
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA			23f. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			Date of Injury (Month, Day, Year) 28a. 28b. Time of Injury M	Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred				
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)						
		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29c. License number D0066086			29d. Date signed (Month, Day, Year) Feb 21, 2012			
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kevin Groszkowski, MD 116 Defense Highway, Suite 400 Annapolis, MD 21401			31. Date filed (Month, Day, Year) FEB 22 2012			32. Registrar's Signature Anna S. Park			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1 - For State Registrar AMEND#17 per INF, 3/7/12; BMW, MCo

Certificate of Death

Reg. No.

2012 07840

Physician/
Medical
Examiner

Funeral
Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit slip.

State
Registrar

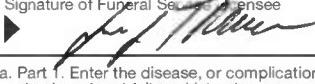
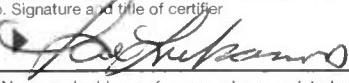
1. Decedent's Name (First, Middle, Last)		Armando Mendez				2. Date of Death Month Day Year	3. Time of Death 2247 M		
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death Silver Spring				4c. County of Death Montgomery			
5. Social Security Number 577-04-5287		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (in yrs. last birthday) 55 Yrs.	If Under 1 Year Months Days Hours Min.	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) May 14, 1956	9. Birthplace (State or Foreign Country) Cuba		
10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Greenbelt			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 6017 Springhill Drive, #202				10f. Zip Code 20770			10g. Citizen of What Country? Cuba		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify: Cuban		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Maintenance Man			16b. Kind of Business/Industry Property Management Co.		
17. Father's Name (First, Middle, Last) Abelardo Mendez Carlos Ruiz				18. Mother's Name (First, Middle, Maiden Surname) Catalina Anuez					
19a. Informant's Name/Relationship (Type, Print) Carlos A. Mendez - Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6017 Springhill Dr., #202, Greenbelt, Maryland 20770					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) ► Amherst Cemetery 1232		20b. Place of Disposition (Name of cemetery, crematory or other place) George Washington Cem		Date 02/25/2012	20c. Location - City or Town, State Adelphi, Maryland				
21. Signature of Funeral Service Licensee ► Ghousia Sultana, M.D.		22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904							
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cardiopulmonary Arrest Due to (or as a consequence of): Stroke Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								Approximate Interval Between Onset and Death	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ► At home		28f. Location (Street and Number or Rural Route Number, City or Town, State) 12107 Heritage Park Circle, Silver Spring, Maryland 20906					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number D56691				29d. Date signed (Month, Day, Year) February 20, 2012			
30. Name and address of person who completed cause of death (Item 29a) (Type, Print) ► Ghousia Sultana, M.D., 12107 Heritage Park Circle, Silver Spring, Maryland 20906								31. Date filed (Month, Day, Year) FEB 27 2012	
32. Registrar's Signature Debra B. Parker									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registra AMEND#23a(a)perMD, 2/27/12; EMW, MoCo Certificate of Death

Reg. No. 2012 07841

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) Lawrence Patrick Mallon						2. Date of Death Month Day Year February 25, 2012		3. Time of Death M 07:55				
Funeral Director		4a. Facility Name (if not institution, give street and number) Mandarin In-Patient Hospice			4b. City, Town, or Location of Death Harwood			4c. County of Death Anne Arundel						
To Be Completed by Funeral Director		5. Social Security Number 213-80-7523		6. Sex 1 X M 2 □ F	7. Age (in yrs. last birthday) 51 Yrs.	If Under 1 Year Months Days Hours Min.	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) APR 06, 1960	9. Birthplace (State or Foreign Country) DC					
To Be Completed by Funeral Director		10a. State MD	10b. County Prince George's	10c. City, Town or Location College Park						10d. Inside City Limits 1 □ Yes 2 X No				
To Be Completed by Physician/Medical Examiner		10e. Street and Number 9504 50th Avenue			10f. Zip Code 20740			10g. Citizen of What Country? United States						
To Be Completed by Physician/Medical Examiner		11. Marital Status 1 □ Never Married 2 □ Married 3 X Widowed 4 □ Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 X No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 X No Specify:			14. Race - American Indian, Black, White, etc. Specify: Caucasian					
To Be Completed by Physician/Medical Examiner		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Landscaper			16b. Kind of Business/Industry Self Employed						
To Be Completed by Physician/Medical Examiner		17. Father's Name (First, Middle, Last) John Joseph Mallon				18. Mother's Name (First, Middle, Maiden Surname) Dorothy Marie Klink								
To Be Completed by Physician/Medical Examiner		19a. Informant's Name/Relationship (Type, Print) Timothy Feresten / Friend			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 Olivewood Court, Greenbelt, MD 20770									
To Be Completed by Physician/Medical Examiner		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 X Removal from State 4 X Donation 5 □ Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Life Legacy Foundation			Date 02/26/2012	20c. Location - City or Town, State Tucson, AZ					
To Be Completed by Physician/Medical Examiner		21. Signature of Funeral Service Ensemble 			22. Name and Address of Facility Thibadeau Mortuary Service, p.a. 7 Park Avenue, Gaithersburg, MD 20877									
To Be Completed by Physician/Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Liver Disease												
To Be Completed by Physician/Medical Examiner		a. Due to (or as a consequence of): Liver Failure												
To Be Completed by Physician/Medical Examiner		b. Due to (or as a consequence of):												
To Be Completed by Physician/Medical Examiner		c. Due to (or as a consequence of):												
To Be Completed by Physician/Medical Examiner		d. Due to (or as a consequence of):												
To Be Completed by Physician/Medical Examiner		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown			23c. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (Specify) 9 □ Unknown						23d. Date of delivery Month Day Year			
To Be Completed by Physician/Medical Examiner		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 □ Probably 4 □ Unknown		
To Be Completed by Physician/Medical Examiner		24a. Was an autopsy performed? 1 □ Yes 2 □ No			24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No									
To Be Completed by Physician/Medical Examiner		25. Was case referred to medical examiner? 1 □ Yes 2 X No		26. Place of Death (Check only one) Hospital: 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 □ Nursing Home 5 □ Residence 6 X Other (Specify) Hosp. c.c.										
To Be Completed by Physician/Medical Examiner		27. Manner of Death 1 X Natural 5 □ Pending Investigation 2 □ Accident 6 □ Could not be determined 3 □ Suicide 4 □ Homicide			28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? 1 □ Yes 2 □ No	28d. Describe how injury occurred					
To Be Completed by Physician/Medical Examiner														
To Be Completed by Physician/Medical Examiner					28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
To Be Completed by Physician/Medical Examiner		29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 □ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
To Be Completed by Physician/Medical Examiner		29b. Signature and title of certifier 			29c. License number D72360			29d. Date signed (Month, Day, Year) 2/25/12						
To Be Completed by Physician/Medical Examiner		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 445 Defense Highway ANNAPOLIS MD 21401												
To Be Completed by Physician/Medical Examiner		31. Date filed (Month, Day, Year) FEB 27 2012			32. Registrar's Signature 									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

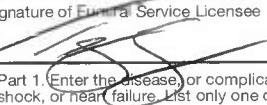
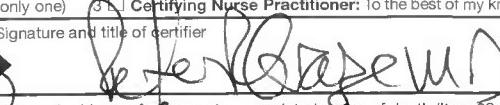
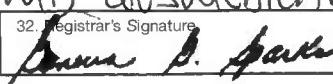
State of Maryland / Department of Health and Mental Hygiene

1 - For AMEND#17 per FH
State Registrar 3/2/2012 AACO HEALTH DEPT. CMH

Certificate of Death

Reg. No.

2012 07842

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary Anne Mitchell						2. Date of Death Month Day Year February 20, 2012	3. Time of Death 3:20 PM		
	4a. Facility Name (if not institution, give street and number) Anne Arundel Medical Center			4b. City, Town, or Location of Death Annapolis			4c. County of Death Anne Arundel			
Funeral Director	5. Social Security Number 236-34-4019	6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) April 30, 1927			9. Birthplace (State or Foreign Country) West Virginia		
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State MD 10b. County Anne Arundel 10c. City, Town or Location Severna Park						10d. Inside City Limits 1 □ Yes 2 X No	
	10e. Street and Number 505 Evergreen Road			10f. Zip Code 21146			10g. Citizen of What Country? USA			
	11. Marital Status 1 □ Never Married 2 □ Married 3 X Widowed 4 □ Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 X No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 X No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Homemaker			16b. Kind of Business/Industry Home			
	17. Father's Name (First, Middle, Last) Junes Barber				18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Goode					
	19a. Informant's Name/Relationship (Type, Print) Anne Mitchell / Daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3072 H Spring Hill Pkwy. SE Smyrna, GA 30080						
	20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington National Cemetery			Date March 06, 2012	20c. Location - City or Town, State Arlington, VA			
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy, Severna Park, MD 21146						
Physician/ Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or near failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CANCER OF OVARY								Approximate Interval Between Onset and Death 3 MONTHS	
	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 X No 9 □ Unknown									
	23c. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown									
	23d. Date of delivery Month Day Year									
Medical Certificate: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 X No 3 □ Probably 4 □ Unknown	
									24a. Was an autopsy performed? 1 □ Yes 2 X No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 X No
	25. Was case referred to medical examiner? 1 □ Yes 2 X No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)							
	27. Manner of Death 1 X Natural 5 □ Pending Investigation 2 □ Accident 6 □ Could not be determined 3 □ Suicide 4 □ Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? 1 □ Yes 2 □ No	28d. Describe how injury occurred			
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 □ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 						29c. License number D16364	29d. Date signed (Month, Day, Year) 02/21/12
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frank Green MD 2005 MEDICAL PKWY 210 ANNAPOLIS MD 21401									
	31. Date filed (Month, Day, Year) FEB 24 2012		32. Registrar's Signature 							

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

CH 15
State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07843

Physician/
Medical
Examiner

1 - For
State
Registrar

1. Decedent's Name (First, Middle, Last)

Dorothy Louise McDowell

2. Date of Death

Month

Day

Year

3. Time of Death

February 22, 2012

10:48 P M

Funeral
Director

4a. Facility Name (if not institution, give street and number)

874 Rudder Way

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

5. Social Security Number

087-14-2621

Usual Residence of Decedent

6. Sex

1 M 2 F

7. Age (In yrs. last birthday)

89

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

8. Date of Birth

(Month, Day, Year)

May 9,

1922

9. Birthplace (State or Foreign Country)

New York

Baltimore, Maryland 21215-0036
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

874 Rudder Way

10f. Zip Code

21401

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) 12th

College (1-4 or 5+) Homemaker

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Albert Sheffield

18. Mother's Name (First, Middle, Maiden Surname)

Marguerite Fredenburg

19a. Informant's Name/Relationship (Type, Print)

Carolyn Taylor/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

670 W. Central Ave., Davidsonville, MD 21035

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Kalas Crematory

Date

2/24/12

20c. Location - City or Town, State

Edgewater, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

George P. Kalas Funeral Home

2973 Solomons Island Rd. Edgewater, MD 21037

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

CANCER LUNG

Approximate Interval Between Onset and Death

14 mos

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No
9 Unknown

23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (Specify)
9 Unknown

23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?
1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

Other:

4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 5 Pending Investigation
2 Accident 6 Could not be determined
3 Suicide
4 Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?
1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

DO8118

29d. Date signed (Month, Day, Year)

FEB 23 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SIMPLY ATKINS MD 2003 MEDICAL RD ANNAPOLIS MD 21401

31. Date filed (Month, Day, Year)

FEB 24 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend Item 25 per me, g925, 03/29/2012dhn Certificate of Death

Reg. No. 2012 07844

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Lester Martin				2. Date of Death Month 02 Day 20 Year 2012	3. Time of Death 10:00a M	
	4a. Facility Name (if not institution, give street and number) Anne Arundel Medical Center				4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arundel
Funeral Director	5. Social Security Number 577-52-2871	6. Sex XX M	7. Age (in yrs. last birthday) 74 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 11/22/1937	9. Birthplace (State or Foreign Country) Maryland
	10a. State Maryland				10b. County Prince George's		10c. City, Town or Location Bowie
10e. Street and Number 14413 Jericho Park Road				10f. Zip Code 20715		10g. Citizen of What Country? U.S.A.	
To Be Completed by Funeral Director	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. White Specify:
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Excavating		16b. Kind of Business/Industry Contractor		
17. Father's Name (First, Middle, Last) Herman F. Martin				18. Mother's Name (First, Middle, Maiden Surname) Bertha Mae Phile			
19a. Informant's Name/Relationship (Type, Print) Helen R. Martin - WIFE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14413 Jericho Park Road, Bowie, Md. 20715			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Ft. Lincoln Cemetery		Date 2/22/12	20c. Location - City or Town, State Brentwood, Md.		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road, Bowie, Md. 20715			
Physician/ Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)						
	a. Intracerebral Hemorrhage Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____						
							Approximate Interval Between Onset and Death 5 days
Physician/ Medical Examiner	23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown						
	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown						
23d. Date of delivery Month Day Year							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No							
26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide							
28a. Date of injury (Month, Day, Year) 28b. Time of injury M 28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
28d. Describe how injury occurred							
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier Keith Goulet, M.D.							
29c. License number 10020408							
29d. Date signed (Month, Day, Year) 2-20-12							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Keith Goulet 2001 Medical Parkway Annapolis, MD							
31. Date filed (Month, Day, Year) FEB 22 2012							
32. Registrar's Signature Renata S. Parker							

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

CHD
State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07845

1- For
State
RegistrarPhysician/
Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Patricia H. McNitt

2. Date of Death

Month

Day

Year

3. Time of Death

February

19

2012

6:40 P M

Funeral
Director

4a. Facility Name (if not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

5. Social Security Number

106-24-4984

6. Sex

1 M2 F

7. Age (In yrs. last birthday)

85

Yrs.

If Under 1 Year

Months

Days

8. Date of Birth

(Month, Day, Year)

9. Birthplace (State or Foreign Country)

June 1, 1926

New Jersey

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

8211 River Crescent Drive

10f. Zip Code

21401

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Year or Dates.13. Was Decedent of Hispanic Origin? (Specify Yes or No)
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Interior Designer

16b. Kind of Business/Industry

Design

17. Father's Name (First, Middle, Last)

Thomas E. Hicks

18. Mother's Name (First, Middle, Maiden Surname)

Mary Reeves

19a. Informant's Name/Relationship (Type, Print)

Robert McNitt/husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8211 River Crescent Drive Annapolis, Maryland 21401

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Atlantic Crematory

Date

20c. Location - City or Town, State

2/22/2012

Glen Burnie, Maryland

21. Signature of Funeral Service Licensee

Jordi E. Liller

22. Name and Address of Facility

John M. Taylor Funeral Home
147 Duke of Gloucester St., Annapolis, MD 21401

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Pneumonia

Approximate Interval Between Onset and Death
2 days

a. Due to (or as a consequence of):

Severe Bronchiectasis

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No
9 Unknown23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify)
9 Unknown23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

Other:

4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 5 Pending Investigation
2 Accident 6 Could not be determined
3 Suicide 4 Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
(Check only one)
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M. Clance

29c. License number

D38328

29d. Date signed (Month, Day, Year)

February 19, 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mary Ruth Clance, MD 2001 Medical Parkway Annapolis, MD 21401

31. Date filed (Month, Day, Year)

FEB 22 2012

32. Registrar's Signature

Barbara A. Parker

Baltimore, Maryland 21215-0036
Permit Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transitState
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07846

1- For
State
RegistrarPhysician/
Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Division of Vital Records, P.O. Box 68760

Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) MARTHA NORTH			2. Date of Death Month 2 Day 21 Year 2012 5 AM	3. Time of Death		
4a. Facility Name (if not institution, give street and number) 715 210th Street			4b. City, Town, or Location of Death Pasadena		4c. County of Death Anne Arundel	
5. Social Security Number 213-32-6113		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Aug. 5, 1930	9. Birthplace (State or Foreign Country) Maryland
10a. State Maryland		10b. County Anne Arundel	10c. City, Town or Location Pasadena			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number 715 210th Street			10f. Zip Code 21122		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. White Specify:
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 3		16b. Kind of Business/Industry Homemaker		16c. Kind of Business/Industry Own home
17. Father's Name (First, Middle, Last) Roy Morgan			18. Mother's Name (First, Middle, Maiden Surname) Martha Simon			
19a. Informant's Name/Relationship (Type, Print) Robert North/husband			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 715 210th Street Pasadena, Maryland 21122			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore Crematory		Date 2/23/2012	20c. Location - City or Town, State Baltimore, Maryland	
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401			

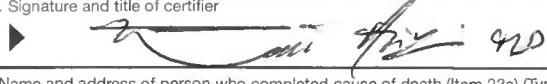
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death
<p>a. Due to (or as a consequence of): <i>End Stage Chronic Obstructive Pulmonary Disease</i></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		

IF FEMALE:	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) _____	23d. Date of delivery Month Day Year
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Coronary artery disease Diabetes, renal failure</i>		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown	
		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No

25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide	28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
--

29b. Signature and title of certifier 	29c. License number D14774	29d. Date signed (Month, Day, Year) 2-21-2012
--	--------------------------------------	---

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHAHID AZIZ M.D. 445 DEFENSE Hvy, ANNAPOLIS, Md 21401		
31. Date filed (Month, Day, Year) FEB 22 2012	32. Registrar's Signature 	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07847

1- For State Registrar

**Physician/
Medical
Examiner**

**Funeral
Director**

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last) Margaret Elizabeth Ogden				2. Date of Death Month Day Year February 19 2012	3. Time of Death 7:21 PM			
4a. Facility Name (if not institution, give street and number) 955 Western Shores Blvd.				4b. City, Town, or Location of Death Port Republic				
4c. County of Death Calvert								
5. Social Security Number 213-42-9729		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 91 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Sept 17 1920	9. Birthplace (State or Foreign Country) Maryland		
10a. State Maryland						10b. County Calvert	10c. City, Town or Location Port Republic	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
10e. Street and Number 955 Western Shores Blvd.				10f. Zip Code 20676		10g. Citizen of What Country? United States		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. white Specify:		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) grocery store owner/operator			16b. Kind of Business Industry retail sales		
17. Father's Name (First, Middle, Last) Irving C. Bowen				18. Mother's Name (First, Middle, Maiden Surname) Fannie M. Hutchins				
19a. Informant's Name/Relationship (Type, Print) Margaret D. Bladen- daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 955 Western Shores Blvd. Port Republic, MD 20676				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) Braunsch			20b. Place of Disposition (Name of cemetery, crematory or other place) Wesley Cemetery		Date 02/24/2012	20c. Location - City or Town, State Prince Frederick MD		
21. Signature of Funeral Service Licensee Braunsch			22. Name and Address of Facility Rausch Funeral Home PA 4405 Broomes Is. Rd. Port Republic, MD 20676					

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death 4 years				
<p>a. <u>Congestive heart failure</u> Due to (or as a consequence of):</p> <p>b. <u>atrial fibrillation</u> Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Late effects cerebrovascular disease diabetes mellitus, controlled						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number D0028544				29d. Date signed (Month, Day, Year) 02/22/2012		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 23348 Nicholson Street, Hollywood, Maryland 20636						31. Date filed (Month, Day, Year) FEB 23 2012		
32. Registrar's Signature Suzanne S. Farber								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07848

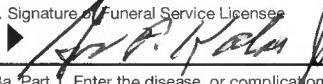
1 - For
State
Registrar

Physician/
Medical
Examiner

Funeral
Director

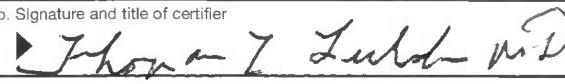
Baltimore, Maryland 21215-0036
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 2 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) Edwin Cooper Orndorff			2. Date of Death Month February Day 19 , Year 2012	3. Time of Death 3:09P M
4a. Facility Name (if not institution, give street and number) Civista Hospital			4b. City, Town, or Location of Death La Plata	
4c. County of Death Charles				
5. Social Security Number 220-62-6505		6. Sex 1 X M 2 F	7. Age (In yrs. last birthday) 57 Yrs.	If Under 1 Year Months 7 Days 8 Hours 19 Min. 45
8. Date of Birth (Month, Day, Year) 7/8/1954			9. Birthplace (State or Foreign Country) Maryland	
Usual Residence of Decedent				
10a. State Maryland	10b. County Anne Arundel	10c. City, Town or Location Glen Burnie		
10e. Street and Number 7866 Americana Circle			10f. Zip Code 21060	10g. Citizen of What Country? USA
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Environmental Technician		16b. Kind of Business Industry Transportation
17. Father's Name (First, Middle, Last) Edwin C. Orndorff			18. Mother's Name (First, Middle, Maiden Surname) Dolores A. Hunt	
19a. Informant's Name/Relationship (Type, Print) Ian D. Orndorff/Son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12415 Ramsdell Drive Rockford, MI 49341	
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Kalas Crematory		Date 2/25/2012
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037		

To Be Completed by Physician/Medical Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Myocardial Infarction		Approximate Interval Between Onset and Death Minutes
a.	Due to (or as a consequence of): Coronary Heart Disease			4 Months
b.	Due to (or as a consequence of):			
c.	Due to (or as a consequence of):			
d.	Due to (or as a consequence of):			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number D001923		
29b. Signature and title of certifier 		29d. Date signed (Month, Day, Year) February 22, 2012		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas L. Fieldson, M.D. 2068 Crain Hwy., Waldorf, MD 20601				
31. Date filed (Month, Day, Year) FEB 23 2012		32. Registrar's Signature 		

ED
6
State
Registrar

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0036

Original

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07849

1 - For
State
RegistrarPhysician/
Medical
Examiner

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

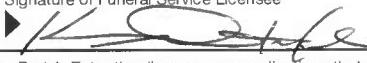
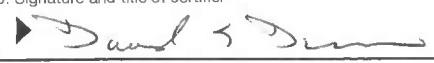
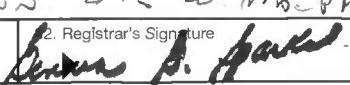
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trust.

10

Medical Certificate: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death		
Max Polack		February 21, 2012				8:10 PM		
4a. Facility Name (if not institution, give street and number) Avondale Assisted Living			4b. City, Town, or Location of Death Bel Air			4c. County of Death Harford		
5. Social Security Number 214-12-1012		6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month Day Year) 03/15/1921	9. Birthplace (State or Foreign Country) Maryland	
Usual Residence of Decedent		10a. State MD 10b. County Harford 10c. City, Town or Location Bel Air						10d. Inside City Limits 1 Yes 2 No
10e. Street and Number 128 W. Ring Factory Road			10f. Zip Code 21014			10g. Citizen of What Country? United States		
11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No WWII If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:			14. Race - American Indian, Black, White, etc. White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)		16b. Kind of Business/Industry Sales			16c. Location - City or Town, State Retail	
17. Father's Name (First, Middle, Last) Jacob Polack				18. Mother's Name (First, Middle, Maiden Surname) Minnie Kokalenska				
19a. Informant's Name/Relationship (Type, Print) Samuel Joseph Polack-Son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2803 Grey Antler Court Abingdon, MD 21009					
20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Judean Mem Grdns			Date 02/23/2012	20c. Location - City or Town, State Olney, Maryland	
21. Signature of Funeral Service Licensee 			Chapels, Inc. 1700 Rockville Memorial Rockville, MD 20852					
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
<p>a. <i>end stage cardiovascular</i> Due to (or as a consequence of):</p> <p>b. <i>CHF</i> Due to (or as a consequence of):</p> <p>c. <i>CKD</i> Due to (or as a consequence of):</p> <p>d. <i>HTN</i> Due to (or as a consequence of):</p>								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)				23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>chronic renal failure</i> <i>HTN</i> <i>CHF</i>								
23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown								
24a. Was an autopsy performed? 1 Yes 2 No		24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No						
25. Was case referred to medical examiner? 1 Yes 2 No		26. Place of Death (Check only one) Hospital: Assisted Living						
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 Yes 2 No	28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier 1 Physician 2 Medical Examiner 3 Certified Nurse Practitioner : To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 		29c. License number D32287			29d. Date signed (Month, Day, Year) February 22, 2012			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David S Dunn 615 W. North St.								
31. Date filed (Month, Day, Year) FEB 27 2012		32. Registrar's Signature 						

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 2 should be detached for use as the burial-transit permit.

Important: If item 27 is marked other than "natural", or items 23a or 26a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07850

1 - For State Registrar

Physician/
Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last)

Elaine Marie Prout

2. Date of Death

Month Day Year
February 18, 2012

3. Time of Death

3:47 a M

4a. Facility Name (if not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

5. Social Security Number

216-02-7405

Usual Residence of Decedent

6. Sex

1 M 2 F

7. Age (In yrs. last birthday)

44

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)

May 3, 1967

9. Birthplace (State or Foreign Country)

New York

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Crofton

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

1730 Tedbury Street

10f. Zip Code

21114

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Information Clerk

16b. Kind of Business/Industry

Library

17. Father's Name (First, Middle, Last)

John P. Wood

18. Mother's Name (First, Middle, Maiden Surname)

Claire J. Qubik

19a. Informant's Name/Relationship (Type, Print)

Lonnie F. Prout/husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1730 Tedbury Street, Crofton, MD 21114

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

Date

20c. Location - City or Town, State

2-21-2012

Baltimore, MD

21. Signature of Funeral Service Licensee

{

22. Name and Address of Facility

Beall Funeral Home

6512 NW Crain Hwy., Bowie, Maryland 20715

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death

6 weeks

a. METASTATIC CARCINOMA UNKNOWN PRIMARY SITE

Due to (or as a consequence of):

{

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No
9 Unknown23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify)
9 Unknown23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown24a. Was an autopsy performed?
1 Yes 2 No24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No25. Was case referred to medical examiner?
1 Yes 2

Hospital:

1

Inpatient

2 ER/Outpatient3 DDA

Other:

4 Nursing Home5 Residence6 Other (Specify)

27. Manner of Death

1 Natural
2 Accident
3 Suicide
4 Homicide5 Pending Investigation
6 Could not be determined28a. Date of injury
(Month, Day, Year)

28b. Time of injury

28c. Injury at work?

M 1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Peter Grade MD 2025 Medical Pkwy 2D Annapolis MD 21401

31. Date filed (Month Day Year)

FEB 23 2012

32. Registrar's Signature

Anna S. Parker

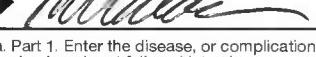
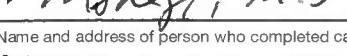
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07851

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) Olga N. Pavloff						2. Date of Death Month Day Year February 20, 2012		3. Time of Death 5:05 P M	
Funeral Director		4a. Facility Name (if not institution, give street and number) FutureCare Chesapeake			4b. City, Town, or Location of Death Arnold			4c. County of Death Anne Arundel			
To Be Completed by Funeral Director		5. Social Security Number 572-44-2863		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) June 13, 1923	9. Birthplace (State or Foreign Country) China		
		Usual Residence of Decedent		10a. State Maryland			10b. County Anne Arundel			10c. City, Town or Location Annapolis	
		10e. Street and Number 1603 Orchard Way					10f. Zip Code 21409			10g. Citizen of What Country? USA	
		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Homemaker			16b. Kind of Business Industry Home				
		17. Father's Name (First, Middle, Last) Nicholas Ilyinich					18. Mother's Name (First, Middle, Maiden Surname) Helen Case				
		19a. Informant's Name/Relationship (Type, Print) Marguerite D. Pavloff/ Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1603 Orchard Way, Annapolis, MD 21409							
		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Hillcrest Cemetery			Date 2/ 24/12	20c. Location - City or Town, State Annapolis, Maryland			
		21. Signature of Funeral Service Licensee 		22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037							
Physician/ Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)						Approximate Interval Between Onset and Death			
		a. <i>End stage dementia</i> Due to (or as a consequence of):									
		b. _____ Due to (or as a consequence of):									
		c. _____ Due to (or as a consequence of):									
		d. _____									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)									
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier 		29c. License number D57531			29d. Date signed (Month, Day, Year) February 20, 2012						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mohit Negi, M.D. 8601 Veterans Hwy., Millersville, Maryland 21108											
31. Date filed (Month, Day, Year) FEB 22 2012		32. Registrar's Signature 									
State Registrar											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For
State
Registrar

Certificate of Death

Reg. No. 2012 07852

Physician/
Medical
Examiner

1. Decedent's Name (First, Middle, Last)							2. Date of Death Month February Day 25 Year 2012	3. Time of Death 0030 M
Carmela Rascona							4b. City, Town, or Location of Death Olney	
4a. Facility Name (if not institution, give street and number) 4509 Random Ridge Circle			4c. County of Death Montgomery					

Baltimore, Maryland 21215-0036
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

State
Registrar

Medical Certificate: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

5. Social Security Number 579-42-6610	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) July 14, 1924	9. Birthplace (State or Foreign Country) PA
Usual Residence of Decedent						
10a. State MD	10b. County Montgomery	10c. City, Town or Location Olney				
10e. Street and Number 4509 Random Ridge Circle			10f. Zip Code 20832			10g. Citizen of What Country? USA
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business Industry Own Home	
17. Father's Name (First, Middle, Last) Fillipo Sottile				18. Mother's Name (First, Middle, Maiden Surname) Anotonina Sparacino		
19a. Informant's Name/Relationship (Type, Print) Gina Ziegenbein/Daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4509 Random Ridge Circle, Olney, MD 20832			
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) entombment		20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery		Date Feb. 28, 2012	20c. Location - City or Town, State Silver Spring, MD	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901				

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		a. <u>Alzheimer's disease</u> Due to (or as a consequence of):			Approximate Interval Between Onset and Death years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. _____ Due to (or as a consequence of):			
		c. _____ Due to (or as a consequence of):			
		d. _____			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____			23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number D42046			
29b. Signature and title of certifier 		29d. Date signed (Month, Day, Year) February 25, 2012			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Grace Brooke Huffman, M.D. 1355 Piccard Drive Suite 100 Rockville, Maryland 20850					
31. Date filed (Month, Day, Year) FEB 27 2012		32. Registrar's Signature 			

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07853

1- For State
Registrar

1. Decedent's Name (First, Middle, Last)

Denis Ercelio Escobar Romero

2. Date of Death

Month Day Year

February 28, 2012

3. Time of Death

1130 hrs

Physician/
Medical ExaminerFuneral
Director

To Be Completed by Funeral Director

B
Medical Certification: To Be Completed by Physician/Medical Examiner

4a. Facility Name (if not institution, give street and number) Wilson Flow Park-1000 Beech Drive				4b. City, Town, or Location of Death Middle River				4c. County of Death Baltimore County	
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5. Social Security Number None		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 29 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (MM/DD/YYYY) 08/06/1982	9. Birthplace (State or Foreign Country) Honduras
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Usual Residence of Decedent 10a. State Md								10b. County Baltimore	10c. City, Town or Location Rosedale	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
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10e. Street and Number 18 King Charles Cir.				10f. Zip Code 21237				10g. Citizen of What Country? Honduras
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11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <small>If Yes, Give Year or Dates:</small>	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <small>specify: Honduras</small>	14. Race - American Indian, Black, White, etc. <small>Specify: Hispanic</small>
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15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Labor	16b. Kind of Business/Industry Construction
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17. Father's Name (First, Middle, Last) Ercilio Escobar Vasquez				18. Mother's Name (First, Middle, Maiden Surname) Blanca Lidia Alfaro Romero			
--	--	--	--	---	--	--	--

19a. Informant's Name/Relationship (Type, Print) Ercilio Escobar Vasquez/Father				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18 King Charles Cir. Rosedale, Md. 21237			
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20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other Specify:	20b. Place of Disposition (Name of cemetery, crematory or other place) General Cemetery	Date 03/12/12	20c. Location - City or Town, State Honduras
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21. Signature of Funeral Service Licensee <i>George Baller</i>	22. Name and Address of Facility John T. Rhines Funeral home 3005 12th. St. NE Washington D.C. 20017
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23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Cocaine and alcohol Intoxication complicated by drowning				Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)				a. Due to (or as a consequence of):
				b. Due to (or as a consequence of):
				c. Due to (or as a consequence of):
				d.
<input checked="" type="checkbox"/> UNPENDED	<input type="checkbox"/> AMENDED 23a, 27, 28a-f, per me, g925 3-15-12 sm			

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
				24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
				24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA	26. Place of Death (Check only one) Other <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other: Scene
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27. Manner of Death 1 <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day, Year) fd 2-28-12	28b. Time of Injury fd 11:26 am	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred unknown
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Found: In River				28f. Location (Street and Number or Rural Route Number, City or Town, State) 1000 Beech Dr. Wilson Flow Park Middle River, MD.

29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) February 29, 2012
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30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

31. Date filed (Month, Day, Year) MAR 07 2012	32. Registrar's Signature <i>James P. Farrel</i>
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07854

1- For
State
RegistrarPhysician/
Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/
Medical
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. Decedent's Name (First, Middle, Last) <i>Edward Reio</i>			2. Date of Death Month <input checked="" type="checkbox"/> 2 Day <input type="checkbox"/> 22 Year <input type="checkbox"/> 2012	3. Time of Death M <input type="checkbox"/> 12 H <input type="checkbox"/> 30 P M	
4a. Facility Name (if not institution, give street and number) <i>Crofton Care & Rehabilitation Center</i>			4b. City, Town, or Location of Death <i>Crofton</i>		
4c. County of Death <i>Anne Arundel</i>					
5. Social Security Number <i>213-38-0281</i>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>82</i> Yrs.	If Under 1 Year Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	8. Date of Birth (Month, Day, Year) <i>July 9, 1929</i>	
9. Birthplace (State or Foreign Country) <i>Maryland</i>					
10a. State <i>MD</i>		10b. County <i>Prince George's</i>	10c. City, Town or Location <i>Bowie</i>		
10e. Street and Number <i>17406 Central Ave.</i>			10f. Zip Code <i>20716</i>	10g. Citizen of What Country? <i>USA</i>	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: 14. Race - American Indian, Black, White, etc. Specify: <i>White</i>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>8</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Mechanic	16b. Kind of Business Industry <i>Prince George's County Board of Education</i>		
17. Father's Name (First, Middle, Last) <i>George R. Reio</i>			18. Mother's Name (First, Middle, Maiden Surname) <i>Elsie Entzian</i>		
19a. Informant's Name/Relationship (Type, Print) <i>Ruth G. Reio / Spouse</i>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>17406 Central Ave., Bowie, MD 20716</i>		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>1st Lutheran Ch. Cem.</i>	Date <i>2/25/2012</i>	20c. Location - City or Town, State <i>Bowie, MD</i>	
21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility <i>Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 20715</i>			
23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)			Approximate Interval Between Onset and Death <i>Atherosclerotic Cerebral Vascular Disease</i>		
<p>a. Due to (or as a consequence of): <i>[Handwritten]</i></p> <p>b. Due to (or as a consequence of): <i>[Handwritten]</i></p> <p>c. Due to (or as a consequence of): <i>[Handwritten]</i></p> <p>d. _____</p>					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input checked="" type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier <i>[Signature]</i>		29c. License number <i>R104317</i>		29d. Date signed (Month, Day, Year) <i>02/22/2012</i>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Diana Ng 6934 Aviation Blvd Suite B, Glen Burnie, MD 21061</i>					
31. Date filed (Month, Day, Year) <i>FEB 24 2012</i>		32. Registrar's Signature <i>[Signature]</i>			

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07855

1- For State Registrar**Physician/Medical Examiner**

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death 0950 hrs
Peter Henry Robinson	February 18, 2012	

Funeral Director

4a. Facility Name (if not institution, give street and number) 600 Quiet Waters Park	4b. City, Town, or Location of Death Annapolis	4c. County of Death Anne Arundel
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To Be Completed by Funeral Director
 Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, MD 21215-0036

5. Social Security Number 220-66-6325	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 56 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (MM/DD/YYYY) June 20 1955	9. Birthplace (State or Foreign Country) Canada
--	--	---	---	---	--

10a. State Maryland	10b. County Anne Arundel	10c. City, Town or Location Annapolis	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
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10e. Street and Number 604 Forest Hill Dr.	10f. Zip Code 21403	10g. Citizen of What Country? USA
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11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: If Yes, Give Year or Dates:	14. Race - American Indian, Black, White, etc. Specify: White
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15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th	College (1-4 or 5+) 0	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Trucking	16b. Kind of Business/Industry Bickering Brothers, Inc.
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17. Father's Name (First, Middle, Last) Thomas Henry Robinson	18. Mother's Name (First, Middle, Maiden Surname) Claudine Celine Devienne
--	---

19a. Informant's Name/Relationship (Type, Print) Claudine Robinson (Mother)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 604 Forest Hill Dr. Annapolis, Md. 21403
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20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State	20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory	Date 2-22-12	20c. Location - City or Town, State Baltimore, Md.
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21. Signature of Funeral Service Licensee <i>Larry H. Reese</i>	22. Name and Address of Facility W.H. Reese & Sons Mortuary, P.A. 1922 Forest Dr. Annapolis, Md. 21401
--	--

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Hanging Due to (or as a consequence of):	Approximate Interval Between Onset and Death
--	--

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. <input type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED	
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IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
	24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No

25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene
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27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day, Year) FOUND: Feb 18, 2012	28b. Time of Injury FOUND: 0950 hrs	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	28d. Describe how injury occurred Subject hanged self
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Park/Recreation Area			28f. Location (Street and Number or Rural Route Number, City or Town, State) 600 Quiet Waters Park, Annapolis, MD

29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. one 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29b. Signature and title of certifier <i>J.W. Titus</i>	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) February 19, 2012
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30. Name and address of person who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

31. Date filed (Month, Day, Year) FEB 22 2012	32. Registrar's Signature <i>Anna S. Jones</i>
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Division of Vital Records, P.O. Box 68760,**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit**State Registrar**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

2012 07855

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1 - For
State
RegistrarPhysician/
Medical
ExaminerFuneral
Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

State
Registrar

Medical Certificate: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Helen Mary Reed		2. Date of Death Month Day Year February 20, 2012		3. Time of Death 3:59 A M
4a. Facility Name (if not institution, give street and number) 819 Windsor Road		4b. City, Town, or Location of Death Arnold		4c. County of Death Anne Arundel
5. Social Security Number 220-56-9898		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) 62 Yrs.	If Under 1 Year Months Days Hours Min. 8. Date of Birth (Month, Day, Year) July 9, 1949
Usual Residence of Decedent Maryland		10b. County Anne Arundel		9. Birthplace (State or Foreign Country) Austria
10a. State Maryland		10c. City, Town or Location Arnold		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
10e. Street and Number 819 Windsor Road		10f. Zip Code 21012		10g. Citizen of What Country? U.S.A.
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 2 Computer Programming		16b. Kind of Business/Industry Government Contractor
17. Father's Name (First, Middle, Last) Charles L. Reed		18. Mother's Name (First, Middle, Maiden Surname) Ann Kay Kellner		
19a. Informant's Name/Relationship (Type, Print) Margery Reed/sister		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 819 Windsor Road Arnold, Maryland 21012		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Bestgate Mem. Park		Date 2/24/2012
21. Signature of Funeral Service Licensee Todd E. Miller		22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401		20c. Location - City or Town, State Annapolis, Maryland
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		b. Due to (or as a consequence of): Breast cancer		Approximate Interval Between Onset and Death 7 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		c. Due to (or as a consequence of):		
d. Due to (or as a consequence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		23f. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Describe how injury occurred
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number DS2830		29d. Date signed (Month, Day, Year) February 20, 2012
29b. Signature and title of certifier Jeanine Werner, MD		32. Registrar's Signature Jeanine S. Parks		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jeanine Werner, MD, 2003 Medical Parkway #210, Annapolis, MD 21401		31. Date filed (Month, Day, Year) FEB 22 2012		32. Registrar's Signature

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07857

1 - For
State
RegistrarPhysician/
Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/
Medical
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. Decedent's Name (First, Middle, Last) MARGARET ROSE				2. Date of Death Month Day Year FEBRUARY 24 2012	3. Time of Death 22:50M		
4a. Facility Name (if not institution, give street and number) WASHINGTON ADVENTIST HOSPITAL				4b. City, Town, or Location of Death TA KOMA PARK			
4c. County of Death MONTGOMERY		4d. County of Death MONTGOMERY					
5. Social Security Number 578-64-3349		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 64 Yrs.	If Under 1 Year Months Days Hours Min. Feb. 27, 1947	8. Date of Birth (Month, Day, Year) Feb. 27, 1947	9. Birthplace (State or Foreign Country) MD	
10a. State DC		10b. County		10c. City, Town or Location Washington			
10e. Street and Number 3015 Douglas St., NE				10f. Zip Code 20018		10g. Citizen of What Country? United States	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Black		14. Race - American Indian, Black, White, etc. Specify:	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Accounting Technician		16b. Kind of Business Industry Government			
17. Father's Name (First, Middle, Last) Richard E. Shelhorse				18. Mother's Name (First, Middle, Maiden Surname) Margaret Elery			
19a. Informant's Name/Relationship (Type, Print) Bernadette Haygood/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3614 Nathalee Avenue Huntsville, AL 35810			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Harmony Memorial Park		20b. Place of Disposition (Name of cemetery, crematory or other place) 3/10/12		20c. Location - City or Town, State Landover, MD			
21. Signature of Funeral Service Licensed Anne Edwards		22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, MD 20746					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) METASTATIC ENDOMETRIAL CANCER							Approximate Interval Between Onset and Death
<p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> <p>a. Due to (or as a consequence of): METASTATIC ENDOMETRIAL CANCER</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC KIDNEY DISEASE							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year) M	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier Anne Edwards MD		29c. License number DO 69051			29d. Date signed (Month, Day, Year) FEBRUARY 25 2012		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BERNICE WILSON A1000, 7800 CARROLL AVENUE, TA KOMA PARK, MD 20912							
31. Date filed (Month, Day, Year) MAR 13 2012		32. Registrar's Signature Suzanne P. Spangler					

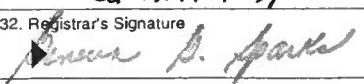
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07858

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Arthur Howard Sullivan III				2. Date of Death Month Day Year February 25 2012	3. Time of Death 00:11 AM			
	4a. Facility Name (If not institution, give street and number) Carroll Hospital Center		4b. City, Town, or Location of Death Westminster		4c. County of Death Carroll				
Funeral Director	5. Social Security Number 213-30-9920	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 80 Yrs.	If Under 1 Year Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Aug 22, 1931	9. Birthplace (State or Foreign Country) Maryland				
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State Maryland			10b. County Carroll			10c. City, Town or Location Westminster	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 335 Hook Road			10f. Zip Code 21157		10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: Korea		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: white		14. Race - American Indian, Black, White, etc.			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Food Broker		16b. Kind of Business/Industry Food Commodities			
	17. Father's Name (First, Middle, Last) Arthur H. Sullivan II				18. Mother's Name (First, Middle, Maiden Surname) Emma Viola Milker				
	19a. Informant's Name/Relationship (Type, Print) Susan S. Noyes, daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3304 Old Taneytown Road, Westminster, MD 21158			Date 2/27/2012	20c. Location - City or Town, State Winfield, MD	
Physician /Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) 21. Signature of Funeral Service Licensee 			20b. Place of Disposition (Name of South Crematory or other place) Carroll Crematory			22. Name and Address of Facility Myers-Durboraw Funeral Home 91 Willis Street, Westminster, MD 21157		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)			Approximate Interval Between Onset and Death					
	<p>a. Bacterial Pneumonia Due to (or as a consequence of):</p> <p>b. Acute Renal Failure Due to (or as a consequence of):</p> <p>c. Failure to Thrive Due to (or as a consequence of):</p> <p>d. _____</p>								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (Specify) _____			23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia, Depression, Diabetes Type 2, Hypertension, Anemia			23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			23f. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29c. License number D69086			29d. Date signed (Month, Day, Year) February 25 2012		
	29b. Signature and title of certifier 			29c. License number D69086			29d. Date signed (Month, Day, Year) February 25 2012		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHINTU SHARMA MD Carroll Hospital Center			32. Registrar's Signature 			31. Date filed (Month, Day, Year) FEB 27 2012		

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit document.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner shall be notified at once.

12x1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07859

1 - For
State
Registrar

Physician/
Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/
Medical
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial ~~certificate~~.

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death 9:48 a.m.
Florence Strauss		February 22, 2012		
4a. Facility Name (if not institution, give street and number) 9700 Carmel Court		4b. City, Town, or Location of Death Bethesda		4c. County of Death Montgomery
5. Social Security Number 119-05-6296	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 93 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) April 01, 1918
9. Usual Residence of Decedent Maryland		10a. State Maryland		9. Birthplace (State or Foreign Country) New York
10b. County Montgomery		10c. City, Town or Location Bethesda		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number 9700 Carmel Court		10f. Zip Code 20817		10g. Citizen of What Country? U.S.A.
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
14. Race - American Indian, Black, White, etc. Specify: Caucasian		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Retailer
16b. Kind of Business/Industry Womens' Fashions		17. Father's Name (First, Middle, Last) David Goldstein		18. Mother's Name (First, Middle, Maiden Surname) Clara Steinhacker
19a. Informant's Name/Relationship (Type, Print) William L. Strauss - Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9700 Carmel Court, Bethesda, Maryland 20817		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify): Ft. Lincoln Crematory
20b. Place of Disposition (Name of cemetery, crematory or other place)				Date 03/02/2012
21. Signature of Funeral Service Licensee S. M. M. 10/18/94		22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc.		20c. Location - City or Town, State Brentwood, Maryland
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23c. Date of delivery Month Day Year
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23d. Date of delivery Month Day Year		Approximate Interval Between Onset and Death Years
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		23f. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Lymphocytic Leukemia		23g. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		23h. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DCA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		23i. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred
				28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number D34590		29d. Date signed (Month, Day, Year) February 23, 2012
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Roy Fried, M.D., 7758 Wisconsin Avenue, #211, Bethesda, Maryland 20814				
31. Date filed (Month Day Year) FEB 27 2012		32. Registrar's Signature Leanne J. Parker		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

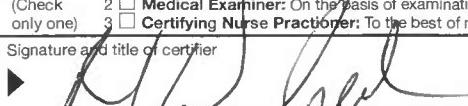
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2012 07860

Reg. No.

1 - For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) James L. Stowe, Jr.					2. Date of Death Month Feb. Day 20 Year 2012	3. Time of Death 12:00 P M		
	4a. Facility Name (if not institution, give street and number) 12000 Hunterton Street		4b. City, Town, or Location of Death Upper Marlboro			4c. County of Death Prince Georges			
Funeral Director	5. Social Security Number 579-62-1870	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 64 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month Day Year) 9/25/1947	9. Birthplace (State or Foreign Country) DC		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State MD 10b. County Prince Georges 10c. City, Town or Location Upper Marlboro						10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 12000 Hunterton Street		10f. Zip Code 20774			10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 4 Police Officer	16b. Kind of Business Industry DC Government						
	17. Father's Name (First, Middle, Last) James L. Stowe, Sr.			18. Mother's Name (First, Middle, Maiden Surname) Ella Finklea					
	19a. Informant's Name/Relationship (Type, Print) Sharon Stowe/Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12000 Hunterton Street Upper Marlboro, Maryland 20774						
Physician/ Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Ft. Lincoln	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 2/27/2012	20c. Location - City or Town, State Brentwood, MD					
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Latney's Funeral Home, Inc. cc0278 3831 Georgia Ave. NW Washington, DC 20011						
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)							Approximate Interval Between Onset and Death	
	a. Anoxic Encephalopathy Due to (or as a consequence of):								
	b. Stroke Due to (or as a consequence of):								
	c. Meningioma Due to (or as a consequence of):								
	d. _____								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
	29b. Signature and title of certifier 		29c. License number D0037529			29d. Date signed (Month, Day, Year) Feb. 24, 2012			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ronald Wheeler, MD 1221 Mercantile Lane Largo, MD 20774								
State Registrar	31. Date filed (Month, Day, Year) FEB 27 2012		32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial transcript.

Medical Certificate: To Be Completed by Physician/Medical Examiner

10

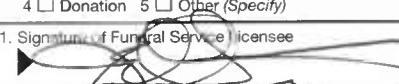
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07861

1 - For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Inna SOLODCHIK				2. Date of Death Month February Day 24 , Year 2012	3. Time of Death 3:05 P M		
	4a. Facility Name (if not institution, give street and number) Holy Cross Hospital		4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery			
Funeral Director	5. Social Security Number 092-74-6366	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) July 23, 1929	9. Birthplace (State or Foreign Country) Russia		
To Be Completed by Funeral Director	10a. State Maryland	10b. County Montgomery	10c. City, Town or Location Silver Spring			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number 1400 Fenwick Lane #814			10f. Zip Code 20910	10g. Citizen of What Country? United States			
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. white Specify:				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Dentist		16b. Kind of Business/Industry Dentistry			
	17. Father's Name (First, Middle, Last) Solomon Solodchik			18. Mother's Name (First, Middle, Maiden Surname) Rebecca Sak				
	19a. Informant's Name/Relationship (Type, Print) Berel Wolvovsky, Rabbi			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 519 Lamberton Dr., Silver Spring, MD 20902				
Physician/ Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Garden of Remembrance	20c. Date of Disposition 02/26/12	20c. Location - City or Town, State Memorial Park Clarksburg, MD			
Medical Certificate: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service licensee 		22. Name and Address of Facility Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 20012					
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Advanced Metastatic Cancer</u> Due to (or as a consequence of): b. <u>Acute Renal Failure</u> Due to (or as a consequence of): c. <u>Failure to Thrive</u> Due to (or as a consequence of): d. <u>Diabetes Mellitus</u>							
	Approximate Interval Between Onset and Death							
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 					
			29c. License number D 66372		29d. Date signed (Month, Day, Year) February 24, 2012			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Majid Rahmannianshahri, M.D., 1500 Forest Glen Road, Silver Spring, MD 20910							
State Registrar	31. Date filed (Month, Day, Year) FEB 27 2012	32. Registrar's Signature 						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

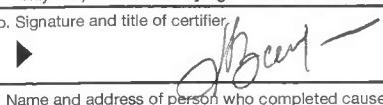
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07862

1- For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Bernard SOBIN				2. Date of Death Month February Day 23 , Year 2012	3. Time of Death 11:00 A M		
	4a. Facility Name (if not institution, give street and number) Arden Courts		4b. City, Town, or Location of Death Kensington		4c. County of Death Montgomery			
Funeral Director	5. Social Security Number 578-44-0281	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (in yrs. last birthday) 92 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) July 8, 1919	9. Birthplace (State or Foreign Country) New York	
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State Maryland 10b. County Montgomery 10c. City, Town or Location Silver Spring						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 3310 N. Leisure World Blvd., #501			10f. Zip Code 20906		10g. Citizen of What Country? United States		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates. WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. white		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) 5+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Economist		16b. Kind of Business Industry U.S. Postal Service			
	17. Father's Name (First, Middle, Last) Mark Sabin			18. Mother's Name (First, Middle, Maiden Surname) Freida Levitt				
	19a. Informant's Name/Relationship (Type, Print) Clifford B. Sabin, Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11700 Old Georgetown Road, #1610, Rockville, MD 20852					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Judean Memorial Gardens		Date 02/24/12	20c. Location - City or Town, State Olney, MD		
	21. Signature of Funeral Service Licensee  M01008		22. Name and Address of Facility Torchnitsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 20012					
	23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	a. Hypertensive Cardiovascular Disease Due to (or as a consequence of):							
	b. Due to (or as a consequence of):							
	c. Due to (or as a consequence of):							
	d. Due to (or as a consequence of):							
	Approximate Interval Between Onset and Death							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) ASSISTED Living					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier 				29c. License number D 0064024		29d. Date signed (Month, Day, Year) 2-23-2012	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Janna Lachchinina, MD 11125 Rockville Pike, #110 Rockville, MD 20852							
State Registrar	31. Date filed (Month, Day, Year) FEB 27 2012		32. Registrar's Signature 					

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Division of Vital Records, P.O. Box 68760

10+1

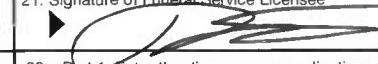
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07863

**1 - For
State
Registrar**

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Ida Sneiderman						2. Date of Death Month 2 Day 22 Year 2012	3. Time of Death 8:30 PM	
	4a. Facility Name (if not institution, give street and number) The Hebrew Home of Greater Washington			4b. City, Town, or Location of Death Rockville			4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 170-16-4784		6. Sex M	7. Age (In yrs. last birthday) 96 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth Month 11 Day 7 Year 1915	9. Birthplace (State or Foreign Country) Ohio	
	Usual Residence of Decedent MD		10a. State MD 10b. County Montgomery		10c. City, Town or Location Rockville			10d. Inside City Limits X Yes 2 <input type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number 6121 Montrose Road				10f. Zip Code 20852		10g. Citizen of What Country? United States		
	11. Marital Status Widowed		12. Was Decedent Ever in U.S. Armed Forces? Yes		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. No			14. Race - American Indian, Black, White, etc. White Specify:	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business Industry Own Home					
17. Father's Name (First, Middle, Last) Harry White				18. Mother's Name (First, Middle, Maiden Surname) Esther Spector					
19a. Informant's Name/Relationship (Type, Print) Marshall Sneiderman - son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6806 Tammy Court Bethesda MD 20817					
20a. Method of Disposition Burial				20b. Place of Disposition (Name of cemetery, crematory or other place) Ohel Jacob Cem.		Date 2/26/2012	20c. Location - City or Town, State Harbor Creek, PA		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Danzansky-Goldberg Memorial Chapels Inc 1170 Rockville Pike Rockville MD 20852					
<p>23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.</p> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. CEREBRAL THROMBOSIS Due to (or as a consequence of):</p> <p>b. ATHEROSCLEROSIS Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>								Approximate Interval Between Onset and Death	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? Yes				23c. If yes, outcome of pregnancy Live Birth				23d. Date of delivery Month Day Year	
				1 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown					
				5 <input type="checkbox"/> Other (specify) _____					
<p>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</p> <p>DIABETES Mellitus, Type 2 HYPERTENSION</p>								23e. Did tobacco use contribute to the cause of death? No	
23f. Was case referred to medical examiner? No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: Nursing Home 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				23g. Did tobacco use contribute to the cause of death? No	
27. Manner of Death Natural				28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work? M	28d. Describe how injury occurred		
						1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier 				29c. License number D0018084		29d. Date signed (Month, Day, Year) FEBRUARY 23, 2012			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DINESH D. PATEL, M.D. 6121 MONTROSE RD, ROCKVILLE MD 20852									
31. Date filed (Month, Day, Year) FEB 27 2012				32. Registrar's Signature 					

Baltimore, Maryland 21215-0036

Permit: Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

Physician/Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial transit slip.

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07864

1 - For
State
Registrar**Physician/
Medical
Examiner**

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death M A M			
Addalee Wilhelm Spear		February 26 2012 10:50 A M			
4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death			
11740 Asbury Circle, Apt. 1103	Solomons	Calvert			
5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-20-3489	1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	88 Yrs.		11/08/1923	Maryland
Usual Residence of Decedent					
10a. State	10b. County	10c. City, Town or Location			
Maryland	Calvert	Solomons			
10e. Street and Number			10f. Zip Code		10g. Citizen of What Country?
11740 Asbury Circle, Apt. 1103			20688		U S A
11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced					
15. Decedent's Education (Specify only highest grade completed)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry
Elementary/Secondary (0-12) 12			College (1-4 or 5+) Homemaker		Home
17. Father's Name (First, Middle, Last)			18. Mother's Name (First, Middle, Maiden Surname)		
Frank Wilhelm			Ivy Williams		
19a. Informant's Name/Relationship (Type, Print)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)		
Kathryn Brozey/daughter			12215 Potomac View Rd., Newburg, MD 20664		
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date	20c. Location - City or Town, State
		Brinsfield-EcholsCrem.		02/28/2012	Charlotte Hall, MD
21. Signature of Funeral Service Licensee John C. Echols III		22. Name and Address of Facility Brinsfield-Echols F.H., P.A. M00817 30195 three Notch Rd., Charlotte Hall, MD 20622			

Medical Certificate: To Be Completed by Physician/Medical Examiner

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death			
<p>a. Due to (or as a consequence of): <i>Failure to Thrive</i></p> <p>b. Due to (or as a consequence of): <i>Dementia</i></p> <p>c. Due to (or as a consequence of):</p> <p>d.</p>					
23b. If female: 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year			
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		23f. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
23g. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		23h. Describe how injury occurred			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier J. John Barth, M.D.			
		29c. License number DO052242		29d. Date signed (Month, Day, Year) 2/27/12	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		31. Date filed (Month, Day, Year) MAR 01 2012			
J. John Barth, M.D., 110 Hospital Rd., Suite 310, Prince Frederick, MD 20678		32. Registrar's Signature Leanne S. Jones			

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10
Form
State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07865

**1 - For
State
Registrar**

**Physician/
Medical
Examiner**

To Be Completed by Funeral Director

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

		1. Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death		
		Johnnie Mae Sawyer					Month Day Year		7:35 A M		
		4a. Facility Name (if not institution, give street and number)					4b. City, Town, or Location of Death		4c. County of Death		
		26875 Three Notch Rd.					Mechanicsville		St. Mary's		
Funeral Director		5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign Country)			
		237-36-3134	1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	83 Yrs.	Months	Days	(Month, Day, Year)	01/27/1929			
		Usual Residence of Decedent						Plymouth, NC			
		10a. State	10b. County	10c. City, Town or Location					10d. Inside City Limits		
		MD	St. Mary's	Mechanicsville					1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
		10e. Street and Number					10f. Zip Code		10g. Citizen of What Country?		
		26875 Three Notch Road					20659		USA		
		11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)					14. Race - American Indian, Black, White, etc.		
		1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married	1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:					Specify: White		
		3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	If Yes, Give Year or Dates.								
		15. Decedent's Education (Specify only highest grade completed)					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry		
		Elementary/Secondary (0-12)		College (1-4 or 5+)		5+ Senior Master Sergeant		U.S. Air Force			
		17. Father's Name (First, Middle, Last)					18. Mother's Name (First, Middle, Maiden Surname)				
		John F. Sawyer					Mary Pearl Warrington				
		19a. Informant's Name/Relationship (Type, Print)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)						
		Sandra B. Farrands / Friend			P.O. BOX 989, Mechanicsville, MD 20659						
		20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)			Date	20c. Location - City or Town, State			
		1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State		Mt. Zion Cemetery			03/02/2012	Mechanicsville, MD			
		4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)									
		21. Signature of Funeral Service Licensee		22. Name and Address of Facility					Approximate Interval Between Onset and Death		
		<i>John F. C. Sawyer #M00817</i>		Brinsfield-Echols F.H., P.A.							
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					30195 Three Notch Road, Charlotte Hall, MD 20622				
		Immediate Cause (Final disease or condition resulting in death)									
		a. Due to (or as a consequence of):									
		b. Due to (or as a consequence of):									
		c. Due to (or as a consequence of):									
		d. Due to (or as a consequence of):									
		IF FEMALE:		23c. If yes, outcome of pregnancy					23d. Date of delivery		
		23b. Was decedent pregnant in the past 12 months?		1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy	4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)	9 <input type="checkbox"/> Unknown	Month	Day	Year		
		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
		9 <input type="checkbox"/> Unknown									
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death?				
							1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
							24a. Was an autopsy performed?			24b. Were autopsy findings available prior to completion of cause of death?	
							1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
		25. Was case referred to medical examiner?		26. Place of Death (Check only one)							
		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
		27. Manner of Death		28a. Date of injury (Month, Day, Year)		28b. Time of injury	28c. Injury at work?	28d. Describe how injury occurred			
		1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation		M		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
		2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined									
		3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
		4 <input type="checkbox"/> Homicide									
		29a. Certifier		1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
		2 <input type="checkbox"/> Medical Examiner		2 <input type="checkbox"/> On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
		3 <input type="checkbox"/> Certifying Nurse Practitioner		3 <input type="checkbox"/> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
		29b. Signature and title of certifier		29c. License number		29d. Date signed (Month, Day, Year)					
		<i>Nilima Jayaraman RN</i>		DUO 31344		2/27/12					
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		<i>Nilima Jayaraman, 28227 Three Notch Rd Mechanicsville</i>							
		31. Date filed (Month, Day, Year)		32. Registrar's Signature							
		MAR 01 2012		<i>Sandra B. Farrands</i>							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1 - For State Amend Item 25 per me, g925, 03/29/2012dhb Certificate of Death 2012 07866
State of Maryland / Department of Health and Mental Hygiene
Registrar Reg. No.

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Francis J. Stromberg				2. Date of Death Month February Day 15 Year 2012	3. Time of Death 8:05 AM		
	4a. Facility Name (if not institution, give street and number) Baltimore Washington Medical Center		4b. City, Town, or Location of Death Glen Burnie		4c. County of Death Anne Arundel			
Funeral Director	5. Social Security Number 216-30-5183	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 78 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) Oct. 14, 1933	9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent 10a. State MD 10b. County Anne Arundel 10c. City, Town or Location Severna Park				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Funeral Director	10e. Street and Number 214 Saint Ives Drive			10f. Zip Code 21146		10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates. 1953-1957		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5 +		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Section Chief		16b. Kind of Business Industry Department of Transportation			
	17. Father's Name (First, Middle, Last) Joseph Stromberg			18. Mother's Name (First, Middle, Maiden Surname) Else Collins				
	19a. Informant's Name/Relationship (Type, Print) Beatrice Stromberg / Wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 214 Saint Ives Drive Severna Park, MD 21146				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MD Veterans Cemetery		Date Feb. 24, 2012	20c. Location - City or Town, State Crownsville, MD		
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy, Severna Park, MD 21146				
	23a. Part I. Enter the disease(s) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head injury. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): INTACARDIAC ALARM Monitor b. Due to (or as a consequence of): Heart Failure c. Due to (or as a consequence of): d. Due to (or as a consequence of): CERTIFICATION APPROVED BY MEDICAL EXAMINER							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of Certifier 		29c. License number 00055703		29d. Date signed (Month, Day, Year) February 15, 2012			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore Washington Medical Center, Glen Burnie MD							
	31. Date filed (Month, Day, Year) FEB 24 2012		32. Registrar's Signature 					

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Within 24 hours after death
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

Francis J. Stromberg, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07867

1- For State Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) George David Sherlock						2. Date of Death Month Day Year February 19, 2012	3. Time of Death 1155 hrs	
	4a. Facility Name (if not institution, give street and number) 486 Eleanor Lane			4b. City, Town, or Location of Death Arnold			4c. County of Death Anne Arundel		
Funeral Director	5. Social Security Number 214-44-4908	6. Sex 1 [X] M 2 [] F	7. Age (in yrs. last birthday) 65	If Under 1 Year Months Days Yrs.	If Under 24 Hrs. Hours Min.	8. Date of Birth (MM/DD/YYYY) 04/18/1946	9. Birthplace (State or Foreign Country) Maryland		
To Be Completed by Funeral Director	10a. State MD 10b. County Anne Arundel 10c. City, Town or Location Arnold						10d. Inside City Limits 1 [] Yes 2 [X] No		
	10e. Street and Number 486 Eleanor Lane			10f. Zip Code 21012			10g. Citizen of What Country? USA		
	11. Marital Status 1 [] Never Married 2 [X] Married	12. Was Decedent Ever in U.S. Armed Forces? 1 [] Yes 2 [X] No	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [] Yes 2 [X] No specify:	14. Race - American Indian, Black, White, etc. Specify: White					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12	College (1-4 or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Firefighter	16b. Kind of Business/Industry Annapolis Fire Department					
	17. Father's Name (First, Middle, Last) Edward P. Sherlock, Sr.			18. Mother's Name (First, Middle, Maiden Surname) Lorraine Brown					
	19a. Informant's Name/Relationship (Type, Print) Marlene Sherlock / Wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 486 Eleanor Lane Arnold, MD 21012					
Physician Medical Examiner	20a. Method of Disposition 1 [] Burial 2 [X] Cremation 3 [] Removal from State	20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, INC.	Date Feb. 22, 2012	20c. Location - City or Town, State Baltimore, MD					
	4 [] Donation 5 [] Other Specify:								
	21. Signature of Funeral Service Licensee			22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy, Severna Park, MD 21146					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.			Approximate Interval Between Onset and Death					
	Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):								
	b. Due to (or as a consequence of):								
	c. Due to (or as a consequence of):								
	d. _____								
	<input type="checkbox"/> UNPENDED	<input type="checkbox"/> AMENDED							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 [] Yes 2 [] No 9 [] Unknown		23c. If yes, outcome of pregnancy 1 [] Live birth 2 [] Fetal death 3 [] Ectopic pregnancy 4 [] Pregnant at time of death 5 [] Other (Specify) 9 [] Unknown			23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus					23e. Did tobacco use contribute to the cause of death? 1 [] Yes 2 [X] No 3 [] Probably 4 [] Unknown			
						24a. Was an autopsy performed? 1 [X] Yes 2 [] No			
						24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [] No			
	25. Was case referred to medical examiner? 1 [X] Yes 2 [] No		26. Place of Death (Check only one) Hospital: 1 [] Inpatient 2 [] ER/Outpatient 3 [] DOA Other: 4 [] Nursing Home 5 [] Residence 6 [X] Other: Scene						
	27. Manner of Death 1 [X] Natural 5 [] Pending Investigation 2 [] Accident 6 [] Could not be determined 3 [] Suicide 4 [] Homicide		28a. Date of Injury (Month, Day, Year) 28b. Time of Injury		28c. Injury at Work? 1 [] Yes 2 [] No		28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc.		
	29a. Certifier 1 [] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number O.C.M.E.			29d. Date signed (Month, Day, Year) February 20, 2012			
	30. Name and address of person who completed cause of death (Item 23a) Mary G. Ripple MD. Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223								
	31. Date filed (Month, Day, Year) FEB 23 2012		32. Registrar's Signature Anna S. Parker						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07868

1- For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Helen Schindler							2. Date of Death Month 2 Day 19 Year 2012	3. Time of Death 8:40 P.M.
	4a. Facility Name (if not institution, give street and number) Anne Arundel Medical Center				4b. City, Town, or Location of Death Annapolis			4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 448-30-2131		6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 76 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) 1/9/1935	9. Birthplace (State or Foreign Country) Missouri	
	Usual Residence of Decedent		10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Bowie		10d. Inside City Limits Yes 2 No
10e. Street and Number 13501 Youngwood Turn				10f. Zip Code 20715			10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:			14. Race - American Indian, Black, White, etc. White Specify:	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)			16b. Kind of Business Industry Archaeologist Private		
17. Father's Name (First, Middle, Last) Dorman Robert Brown				18. Mother's Name (First, Middle, Maiden Surname) Dorothy Helen Cullen					
19a. Informant's Name/Relationship (Type, Print) Joseph Schindler - husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13501 Youngwood Turn, Bowie, Md. 20715					
20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Huntt Crematory			Date	20c. Location - City or Town, State Waldorf, Maryland			
21. Signature of Funeral Service Licensee Alta L. Schindler				22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road, Bowie, Md. 20715					
Physician/ Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Percardial tamponade								Approximate Interval Between Onset and Death
	<p>a. Due to (or as a consequence of): Percardial tamponade</p> <p>b. Due to (or as a consequence of): Metastatic breast cancer</p> <p>c. Due to (or as a consequence of):</p> <p>d. _____</p>								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown			23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown	
								24a. Was an autopsy performed? 1 Yes 2 No	
								24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No	
25. Was case referred to medical examiner? 1 Yes 2 No		26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)							
27. Manner of Death 1 Natural 5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? 1 Yes 2 No	28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier Dr Anne Schindler		29c. License number D66162			29d. Date signed (Month, Day, Year) 02/19/2012				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr Anne Schindler 2001 medical Parkway, Annapolis, Md. 21401									
31. Date filed (Month, Day, Year) FEB 22 2012		32. Registrar's Signature Anna S. Parker							

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit

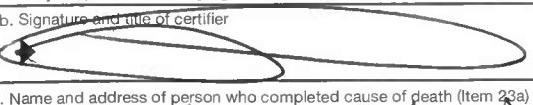
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07869

1 - For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) William F. Sellman					2. Date of Death Month February Day 19 Year 2012	3. Time of Death 2040 M	
	4a. Facility Name (if not institution, give street and number) Anne Arundel Medical Center			4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arundel		
Funeral Director	5. Social Security Number 218-52-7947	6. Sex 1 X M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 63 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) Aug 5 1948	9. Birthplace (State or Foreign Country) D.C.	
To Be Completed by Funeral Director	10a. State Maryland 10b. County Anne Arundel			10c. City, Town or Location Harwood			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 X <input checked="" type="checkbox"/> No	
	10e. Street and Number 4650 Sands Rd.			10f. Zip Code 20776			10g. Citizen of What Country? USA	
	11. Marital Status 1 X Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates. Vietnam		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 X <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 0 Warehouse		16b. Kind of Business/Industry Bob Hall, LLC			
	17. Father's Name (First, Middle, Last) William A. Sellman			18. Mother's Name (First, Middle, Maiden Surname) Edna Bias				
	19a. Informant's Name/Relationship (Type, Print) Helen Anderson (Fiance)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4650 Sands Rd. Harwood, Md. 20776				
	20a. Method of Disposition 1 X Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) LOV Moses			20b. Place of Disposition (Name of cemetery, crematory or other place) LOV Moses		Date 2-25-12	20c. Location - City or Town, State Lothian, Md.	
	21. Signature of Funeral Service Licensee Larry H. Reese			Name and Address of Facility Wm. Reese & Sons Mortuary, P.A. 1922 Forest Dr. Annapolis, Md. 21401				
Physician/ Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sepsis							Approximate Interval Between Onset and Death
Medical Certificate: To Be Completed by Physician/Medical Examiner	23b. Sequential list conditions, if any, leading to immediate cause. Enter Underlying Cause (disease or injury that initiated events resulting in death) Last Pneumonia							
	23c. If female: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown							23d. Date of delivery Month Day Year
	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
	23f. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Mycocardial Infarction Metastatic Colon Cancer							
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DCA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)
	27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							28f. Location (Street and Number or Rural Route Number, City or Town, State)
	29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier 							29c. License number DC0058297
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Howard Young MD Anne Arundel Medical Center Annapolis MD 21401							29d. Date signed (Month, Day, Year) 2/19/2012
State Registrar	31. Date filed (Month, Day, Year) FEB 22 2012			32. Registrar's Signature 				

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07870

1 - For
State
RegistrarPhysician/
Medical
Examiner

		1. Decedent's Name (First, Middle, Last) Nelson Burnette Stockwell						2. Date of Death Month February Day 17 , Year 2012		3. Time of Death 10:15 A M		
		4a. Facility Name (if not institution, give street and number) 974 Riversedge Circle						4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arundel		
Funeral Director		5. Social Security Number 364-05-0633		6. Sex 1 X M 2 □ F		7. Age (In yrs. last birthday) 94 Yrs.		If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth Month 08 Day 31 Year 1917	9. Birthplace (State or Foreign Country) Michigan	
To Be Completed by Funeral Director		Usual Residence of Decedent 10a. State Maryland 10b. County Anne Arundel						10c. City, Town or Location Annapolis				10d. Inside City Limits 1 □ Yes 2 X No
		10e. Street and Number 974 Riversedge Circle						10f. Zip Code 21401		10g. Citizen of What Country? United States		
		11. Marital Status 1 □ Never Married 2 □ Married 3 X Widowed 4 □ Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 X No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 X No Specify: White		14. Race - American Indian, Black, White, etc. Specify:				
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 1						16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Inspector		16b. Kind of Business Industry U.S. Immigration & Naturalization Service		
		17. Father's Name (First, Middle, Last) Clarence Julian Stockwell						18. Mother's Name (First, Middle, Maiden Surname) Lillian Marion Holland				
		19a. Informant's Name/Relationship (Type, Print) Carolyn S. Perry/Daughter						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3512 Mabank Lane, Bowie, Maryland 20715				
		20a. Method of Disposition 1 □ Burial 2 X Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Kalas Crematory		Date 02/20/2012		20c. Location - City or Town, State Edgewater, Maryland				
		21. Signature of Funeral Service Licensee 						22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, MD 21037				
Physician/ Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Colon cancer Approximate Interval Between Onset and Death 5 years										
Medical Certificate: To Be Completed by Physician/Medical Examiner		23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
		23c. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown						23d. Date of delivery Month Day Year				
		23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 X No 3 □ Probably 4 □ Unknown						24a. Was an autopsy performed? 1 □ Yes 2 X No				
		24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No										
		25. Was case referred to medical examiner? 1 □ Yes 2 X No		Hospital: 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA		26. Place of Death (Check only one) Other: 4 □ Nursing Home 5 X Residence 6 □ Other (Specify)		28d. Describe how injury occurred				
		27. Manner of Death 1 X Natural 5 □ Pending Investigation 2 □ Accident 6 □ Could not be determined 3 □ Suicide 4 □ Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at work? 1 □ Yes 2 X No		28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)				
		29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
		29b. Signature and title of certifier 						29c. License number DS2830		29d. Date signed (Month, Day, Year) February 17, 2012		
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jeanine Werner, MD, 2003 Medical Parkway #210, Annapolis, MD 21401										
		31. Date filed (Month, Day, Year) FEB 22 2012		32. Registrar's Signature 								

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

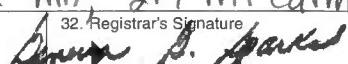
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07871

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Bruce Patric Stauch							2. Date of Death Month Day Year March 6, 2012	3. Time of Death 7:58A M	
	4a. Facility Name (If not institution, give street and number) 21132 Maple Avenue			4b. City, Town, or Location of Death Freeland			4c. County of Death Baltimore			
Funeral Director	5. Social Security Number 214-48-0134	6. Sex M	7. Age (In yrs. last birthday) 63 Yrs.	If Under 1 Year Months 	If Under 24 Hrs. Days 	8. Date of Birth (Month, Day, Year) Mar. 8, 1948	9. Birthplace (State or Foreign Country) MD			
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State MD 10b. County Baltimore 10c. City, Town or Location Freeland								10d. Inside City Limits 1 Yes 2 No	
	10e. Street and Number 21132 Maple Avenue			10f. Zip Code 21053			10g. Citizen of What Country? U.S.A.			
	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: 			14. Race - American Indian, Black, White, etc. White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Real Estate Appraiser			16b. Kind of Business/Industry Real Estate			
	17. Father's Name (First, Middle, Last) John Carroll Stauch				18. Mother's Name (First, Middle, Maiden Surname) Emily Nadyne Langford					
	19a. Informant's Name/Relationship (Type, Print) Lisa Anne Naylor/Wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21132 Maple Ave. Freeland, MD 21053						
	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Cremation Direct Service			Date Mar. 7, 2012	20c. Location - City or Town, State York, PA		
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility JJ Hartenstein Mortuary, Inc 24 N. Second St. New Freedom, PA 17349						
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 2/27/12 - 3/6/12	
	<p>a. <i>metastatic cancer of unknom primary</i> Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____ Due to (or as a consequence of):</p>									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown			23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown			23d. Date of delivery Month Day Year			
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>pathologic fracture left shoulder</i> <i>steroid dependent rheumatoid arthritis</i>								23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown	
	25. Was case referred to medical examiner? 1 Yes 2 No			26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)			24a. Was an autopsy performed? 1 Yes 2 No			24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
	27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide			28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occurred			
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29c. License number D22557			29d. Date signed (Month, Day, Year) 3/6/2012			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Elizabeth Schlenoff MD 214 Mt Carmel Rd, Parktn Md 21120			31. Date filed (Month, Day, Year) MAR 13 2012			32. Registrar's Signature 			

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

15
State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07872

1 - For State Registrar		Decedent's Name (First, Middle, Last)						2. Date of Death		3. Time of Death	
		John Owen Thompson, Sr.						Month March 5, 2012		Year 9:20 AM	
Physician/ Medical Examiner		4a. Facility Name (if not institution, give street and number)						4b. City, Town, or Location of Death		4c. County of Death	
		100 Burgess Hill Way, #208						Frederick		Frederick	
Funeral Director		5. Social Security Number 214-16-1395		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 90 Yrs.		If Under 1 Year Months Days Hours Min.		8. Date of Birth (Month, Day, Year) July 30, 1921	
		Usual Residence of Decedent								9. Birthplace (State or Foreign Country) Maryland	
To Be Completed by Funeral Director		10a. State Maryland		10b. County Frederick		10c. City, Town or Location Frederick				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
		10e. Street and Number 100 Burgess Way #208						10f. Zip Code 21702		10g. Citizen of What Country? United States	
Physician/ Medical Examiner		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates 1942-48		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White	
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12						16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Steel Worker		16b. Kind of Business/Industry Industrial	
		17. Father's Name (First, Middle, Last) Leroy Thompson						18. Mother's Name (First, Middle, Maiden Surname) Irene Easter Lugenbeel			
		19a. Informant's Name/Relationship (Type, Print) John O. Thompson Jr. / Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13110 Parkland Dr., Rockville, Maryland 20853							
		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Prospect Cemetery		Date 03/09/2012		20c. Location - City or Town, State Mt. Airy, Maryland			
		21. Signature of Funeral Service Licensee ► K. Balyard 1646		22. Name and Address of Facility Keeney & Basford Funeral Home 106 E. Church St., Frederick, MD 21701							
Medical Certificate: To Be Completed by Physician/Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death	
		<p>a. <u>Arrhythmia</u> Due to (or as a consequence of):</p> <p>b. <u>Insulin dependent diabetes Mellitus</u> Due to (or as a consequence of):</p> <p>c. <u>Hypertension</u> Due to (or as a consequence of):</p> <p>d. <u>Hypothyroidism</u></p>									
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year			
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Chronic Oedema</u>						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)	
		29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
		29b. Signature and title of certifier ► Leroy Balyard M.D.		29c. License number D50600		29d. Date signed (Month, Day, Year) 3/05/12					
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VA CBOC 1433 Porter Street, Frederick, MD 21702									
State Registrar		31. Date filed (Month, Day, Year) MAR 13 2012		32. Registrar Signature Leroy Balyard							

Baltimore, Maryland 21215-0036

Permit Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10pm

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07873

1- For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last)							2. Date of Death Month Day Year	3. Time of Death
	Adi Vulase Vodo							February 24, 2012	0304 M
Funeral Director	4a. Facility Name (if not institution, give street and number)			4b. City, Town, or Location of Death			4c. County of Death		
	Holy Cross Hospital			Silver Spring			Montgomery		
To Be Completed by Funeral Director	5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months Days Hours Min.	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)	
	213-63-1146		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	56 Yrs.			June 28, 1955	Fiji	
Usual Residence of Decedent		10a. State		10b. County		10c. City, Town or Location		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
Maryland		Montgomery				Silver Spring			
10e. Street and Number					10f. Zip Code		10g. Citizen of What Country?		
816 Easley Street, #1515					20910		Fiji		
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify Pacific Islander	
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced									
15. Decedent's Education (Specify only highest grade completed)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)				16b. Kind of Business/Industry	
Elementary/Secondary (0-12)				College (1-4 or 5+) 1				Clerk Educational Funding	
17. Father's Name (First, Middle, Last)					18. Mother's Name (First, Middle, Maiden Surname)				
Ratu Ilaijia					Adi Bolou Elena				
19a. Informant's Name/Relationship (Type, Print)					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)				
Emosi L. Vodo - Spouse					816 Easley St., #1515, Silver Spring, Maryland 20910				
20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory, or other place)			Date		20c. Location - City or Town, State		
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		Baltimore Crematory at Loudon Park			02/28/2012		Baltimore, Maryland		
21. Signature of Funeral Service Licensee		22. Name and Address of Facility				Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904			
Michelle N. Vodo MO1241									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					Approximate Interval Between Onset and Death				
Immediate Cause (Final disease or condition resulting in death)									
a. Due to (or as a consequence of): Metastatic Embryonal Liver Sarcoma									
b. Due to (or as a consequence of):									
c. Due to (or as a consequence of):									
d. _____									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
					24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
					24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier Gladys H. Lopez, M.D.		29c. License number D0061799			29d. Date signed (Month, Day, Year) February 24, 2012				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)									
Gladys H. Lopez, M.D., 1500 Forest Glen Road, Silver Spring, Maryland 20910									
31. Date filed (Month, Day, Year) FEB 27 2012		32. Registrar's Signature James A. Parker							

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial certificate.

Medical Certificate: To Be Completed by Physician/Medical Examiner

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

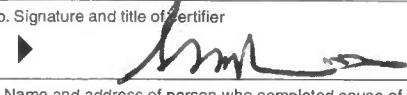
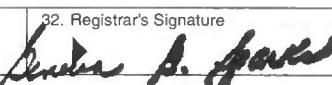
Certificate of Death

Reg. No.

2012

07874

1 - For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) David Samuel Wolman					2. Date of Death Month February Day 24 , Year 2012	3. Time of Death 9:30 A M	
	4a. Facility Name (If not institution, give street and number) 1510 Interlachen Drive, #312					4b. City, Town, or Location of Death Silver Spring	4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 577-40-0135		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 99 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) 03/20/1912	9. Birthplace (State or Foreign Country) Maryland
	10a. State MD		10b. County Montgomery		10c. City, Town or Location Silver Spring			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
To Be Completed by Funeral Director	10e. Street and Number 15100 Interlachen Drive, #312			10f. Zip Code 20906		10g. Citizen of What Country? United States		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 1944- If Yes, Give Year or Dates: 1945		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
Physician /Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Attorney		16b. Kind of Business/Industry Federal Government		
	17. Father's Name (First, Middle, Last) Morris Wolman			18. Mother's Name (First, Middle, Maiden Surname) Jennie Chesler				
Medical Certification: To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type. Print) Anne Wolman Geldon-Daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Golden Crest Court Rockville, MD 20854				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Judean Memorial Grdns		Date 02/27/2012	20c. Location - City or Town, State Olney, Maryland	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial certificate.	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Edward Sagel Funeral Direction, Inc. 1091 Rockville Pike Rockville, MD 20852				
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)			Approximate Interval Between Onset and Death				
{ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consequence of): Respiratory Failure							
	b. Due to (or as a consequence of): Chronic Obstructive Pulmonary Disease							
	c. Due to (or as a consequence of): Coronary Artery Disease							
	d. Due to (or as a consequence of): Hypertension							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____		23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of Certifier 				29c. License number D35579		29d. Date signed (Month, Day, Year) 02-25-2012		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Susan J. Miller, MD 8218 Wisconsin Avenue Bethesda, MD 20814								
31. Date filed (Month, Day, Year) FEB 27 2012			32. Registrar's Signature 					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07875

1 - For
State
RegistrarPhysician/
Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/
Medical
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial bag.

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death	
Patricia Turnbaugh Wessels		February 23, 2012				4:16 a M	
4a. Facility Name (if not institution, give street and number) 2612 Sagebrush Terrace		4b. City, Town, or Location of Death Silver Spring				4c. County of Death Montgomery	
5. Social Security Number 219-28-0938	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 80 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) June 13, 1931	9. Birthplace (State or Foreign Country) MD	
Usual Residence of Decedent 10a. State MD		10b. County Montgomery		10c. City, Town or Location Silver Spring			
10e. Street and Number 2612 Sagebrush Terrace			10f. Zip Code 20905			10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary			16b. Kind of Business Industry National Institutes of Health	
17. Father's Name (First, Middle, Last) Theodore Roosevelt Turnbaugh				18. Mother's Name (First, Middle, Maiden Surname) Grace Callahan			
19a. Informant's Name/Relationship (Type, Print) August Wessels/Husband			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2612 Sagebrush Terrace, Silver Spring, MD 20905				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Union Cemetery			Date Feb. 25, 2012	20c. Location - City or Town, State Leesburg, VA	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901					

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death					
Congestive Heart Failure a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.							
23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown					
23d. Date of delivery Month Day Year							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier 		29c. License number D37142				29d. Date signed (Month, Day, Year) Feb. 23, 2012	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #100 Geoffrey Coleman, MD 1355 Piccard Drive, Rockville, MD 20850							
31. Date filed (Month, Day, Year) FEB 27 2012		32. Registrar's Signature 					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2012 07876

Certificate of Death

Reg. No.

1 - For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Kelvin Bernard Washington, Sr.				2. Date of Death Month Feb. Day 22 , Year 2012	3. Time of Death 7:38 PM		
	4a. Facility Name (if not institution, give street and number) Calvert Memorial Hospital		4b. City, Town, or Location of Death Prince Frederick		4c. County of Death Calvert			
Funeral Director	5. Social Security Number 134-46-7061	6. Sex 1 XX 2 □ F	7. Age (In yrs. last birthday) 56 Yrs.	If Under 1 Year Months Days 	If Under 24 Hrs. Hours Min. 	8. Date of Birth (Month, Day, Year) July 9, 1955	9. Birthplace (State or Foreign Country) New York	
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State Maryland 10b. County Calvert				10c. City, Town or Location Huntingtown		10d. Inside City Limits 1 □ Yes 2 XX No	
	10e. Street and Number 4330 Rhett Butler Court			10f. Zip Code 20639		10g. Citizen of What Country? U.S.A.		
	11. Marital Status 1 □ Never Married 2 XX Married	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 XX No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 XX No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) +4 Stock Broker		16b. Kind of Business Industry International Stocks			
	17. Father's Name (First, Middle, Last) Unknown			18. Mother's Name (First, Middle, Maiden Surname) Mary Unknown				
	19a. Informant's Name/Relationship (Type, Print) Gloria D. Washington - Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4330 Rhett Butler Court, Huntingtown, MD 20639					
Physician Medical Examiner	20a. Method of Disposition 1 □ Burial 2 XX Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lee Crematory		Date Feb. 27, 2012	20c. Location - City or Town, State Clinton, MD		
	21. Signature of Funeral Service Licensee Amanda M. Ergler		22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 8200 Jennifer Lane, Owings, MD 20736					
Medical Certificate: To Be Completed by Physician/Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pulmonary emboli							Approximate Interval Between Onset and Death
	a. Due to (or as a consequence of): Pulmonary emboli							
	b. Due to (or as a consequence of): 							
	c. Due to (or as a consequence of): 							
	d. Due to (or as a consequence of): 							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		23c. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown				23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Coronary Artery disease Diabetes Mellitus Hypertension							23e. Did tobacco use contribute to the cause of death? 1 XX Yes 2 □ No 3 □ Probably 4 □ Unknown
	25. Was case referred to medical examiner? 1 □ Yes 2 □ No		Hospital: 1 XX Inpatient 2 □ ER/Outpatient 3 □ DOA		Other: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)		24a. Was an autopsy performed? 1 XX Yes 2 □ No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
	27. Manner of Death 1 XX Natural 5 □ Pending Investigation 2 □ Accident 6 □ Could not be determined 3 □ Suicide 4 □ Homicide		28a. Date of injury (Month, Day, Year) 	28b. Time of injury M	28c. Injury at work? 1 □ Yes 2 □ No	28d. Describe how injury occurred 		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 		28f. Location (Street and Number or Rural Route Number, City or Town, State) 					
	29a. Certifier (Check only one) 1 XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 □ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number D0052242					
	29b. Signature and title of certifier J. J. Barth		29d. Date signed (Month, Day, Year) 2/24/12					
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Barth 100 Hospital Road Prince Frederick, MD 20678							
	31. Date filed (Month, Day, Year) FEB 27 2012		32. Registrar's Signature Leanne S. Hayes					

Baltimore, Maryland 21215-0036

Permit Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

5
State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07877

1 - For
State
RegistrarPhysician/
Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department. If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last)			2. Date of Death			3. Time of Death		
Donald Robert Wooldridge			Month February Day 20 Year 2012			11:55 PM		
4a. Facility Name (if not institution, give street and number)			4b. City, Town, or Location of Death			4c. County of Death		
Calvert Memorial Hospital			Prince Frederick			Calvert		
5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		9. Birthplace (State or Foreign Country)
215-46-3091		<input checked="" type="checkbox"/> M <input type="checkbox"/> F	66 Yrs.	Months	Days	Hours	Min.	Massachusetts
Usual Residence of Decedent								
10a. State	10b. County	10c. City, Town or Location						
MD	Calvert	Dunkirk						
10e. Street and Number			10f. Zip Code			10g. Citizen of What Country?		
2360 Shields Drive			20754			USA		
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			14. Race - American Indian, Black, White, etc.	
<input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates. 1963-69		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			Specify: White	
15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business Industry			
Elementary/Secondary (0-12) 12		College (1-4 or 5+) Proprietor and Inventor			automation machinery manufacturing company			
17. Father's Name (First, Middle, Last)				18. Mother's Name (First, Middle, Maiden Surname)				
Milo Alfred Wooldridge				Frances Lillian Rice				
19a. Informant's Name/Relationship (Type, Print)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)					
David B. Wooldridge, son			2360 Shields Drive, Dunkirk, MD 20754					
20a. Method of Disposition			20b. Place of Disposition (Name of cemetery, crematory or other place)			Date	20c. Location - City or Town, State	
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			Metropolitan Crematory			02-27-12	Alexandria, VA	
21. Signature of Funeral Service Licensee ► William G. M. M00715			22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 20736					

Physician/
Medical
Examiner

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)				Approximate Interval Between Onset and Death	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		{ a. Due to (or as a consequence of): Carcinomatous Meningitis b. Due to (or as a consequence of): Metastatic Esophageal Cancer c. Due to (or as a consequence of): d. Due to (or as a consequence of):				3 weeks 9 months	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Liver Metastasis Bone Metastasis						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number D0052401		29d. Date signed (Month, Day, Year) February 21, 2012			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas J. Annulis, M.D., 100 Hospital Road, Prince Frederick, MD 20678		32. Registrar's Signature FEB 24 2012 Dennis B. Parker					
31. Date filed (Month, Day, Year)		32. Registrar's Signature					

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For
State
Registrar

Certificate of Death

Reg. No. 2012 07878

Physician/
Medical
Examiner

Funeral
Director

Baltimore, Maryland 21215-0036
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) Ruth Wachs			2. Date of Death Month February Day 21 , Year 2012	3. Time of Death 12:30 A.M.
4a. Facility Name (if not institution, give street and number) Calvert Memorial Hospital			4b. City, Town, or Location of Death Prince Frederick	
5. Social Security Number 207-18-4646			6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.
			If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.
			8. Date of Birth (Month Day Year) 03/03/1928	9. Birthplace (State or Foreign Country) Pennsylvania
Usual Residence of Decedent 10a. State MD			10b. County Calvert	
10c. City, Town or Location Huntingtown			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 2460 Huntingfields Drive			10f. Zip Code 20639	
10g. Citizen of What Country? U.S.A.				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) administrator		16b. Kind of Business Industry optometry
17. Father's Name (First, Middle, Last) Samuel Weinstein			18. Mother's Name (First, Middle, Maiden Surname) Esther Wakser	
19a. Informant's Name/Relationship (Type, Print) Harry Wachs, husband			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2460 Huntingfields Drive, Huntingtown, MD 20639	
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		Date 02/22/2012
21. Signature of Funeral Service Licensee 		20c. Location - City or Town, State Alexandria, VA		
22. Name and Address of Facility Rausch Funeral Home, P.A.		8325 Mt. Harmony Lane, Owings, MD 20736		

Division of Vital Records, P.O. Box 68760
To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate To Be Completed by Physician/Medical Examiner

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final disease or condition resulting in death)				Approximate Interval Between Onset and Death
a. <i>Brill's Disease</i> Due to (or as a consequence of):				
b. <i>Peritonitis</i> Due to (or as a consequence of):				
c. Due to (or as a consequence of):				
d. Due to (or as a consequence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DCA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year) NIA	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
				28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number D17774		
29b. Signature and title of certifier 		29d. Date signed (Month, Day, Year) 2/21/12		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAHIN YAZDANI 100 Hospital Road Prince Frederick, MD 20678				
31. Date filed (Month, Day, Year) FEB 24 2012		32. Registrar's Signature Suzanne S. Parker		

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07879

1 - For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Jack Whitlock</i>				2. Date of Death Month Day Year February 17, 2012	3. Time of Death 3:24 A M	
	4a. Facility Name (if not institution, give street and number) 1205 Pensive Lane		4b. City, Town, or Location of Death Bowie		4c. County of Death Prince George's		
Funeral Director	5. Social Security Number 215-20-3257	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Nov. 16, 1926	9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent MD Prince George's		10a. State 10b. County 10c. City, Town or Location Bowie			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number 1205 Pensive Lane		10f. Zip Code 20716		10g. Citizen of What Country? USA		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates. Navy		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 4 Accountant		14. Race - American Indian, Black, White, etc. Specify: White		
	17. Father's Name (First, Middle, Last) Charles Whitlock		18. Mother's Name (First, Middle, Maiden Surname) Orintha Pearl Barnhart				
	19a. Informant's Name/Relationship (Type, Print) Ruth Matthews / Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 710 Anchor Chain Rd., Unit 1, Ocean City, MD 21842				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MD Veterans Cemetery		Date 2/28/2012	20c. Location - City or Town, State Cheltenham, MD	
	21. Signature of Funeral Service Licensee <i>Jen</i>		22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy, Bowie, Maryland 20715				
Physician/ Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Lung Cancer</i>						Approximate Interval Between Onset and Death 1y
	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>Renal Cell Cancer</i>						1y
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year		
Medical Certificate: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Chronic Aspiration</i>						23e. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <i>D31602</i>		29d. Date signed (Month, Day, Year) <i>2/17/12</i>		
	29b. Signature and title of certifier <i>Burke Curran, MD</i>						
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>George Curran, MD 4201 Mt. Carrollville Rd, Bowie, MD 20716</i>						
State Registrar	31. Date filed (Month, Day, Year) <i>FEB 24 2012</i>	32. Registrar's Signature <i>Leanne S. Parker</i>					

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

10/11

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07880

1 - For
State
Registrar

Physician/
Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036
Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
Donald L. Winter		Month Day Year		7:08 A M
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
Anne Arundel Medical Center		Annapolis		Anne Arundel
5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	8. Date of Birth (Month, Day, Year)
173-16-4880		1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	92 Yrs.	1/21/1920
Usual Residence of Decedent		If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	9. Birthplace (State or Foreign Country) Pennsylvania
10a. State	10b. County	10c. City, Town or Location		
Maryland	Anne Arundel	Edgewater		
10e. Street and Number		10f. Zip Code		10g. Citizen of What Country?
144 Washington Rd.		21037		USA
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry
Elementary/Secondary (0-12)		College (1-4 or 5+) 3 years		Engineer Construction
17. Father's Name (First, Middle, Last)			18. Mother's Name (First, Middle, Maiden Surname)	
Charles C. Winter			Margaret Davies	
19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)		
Donaileen W. Dondero/ Daughter		15 Appaloosa Way, Edgewater, MD 21037		
20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		Kalas Crematory		2/22/12
21. Signature of Funeral Service Licensee		22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037		
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.		Approximate Interval Between Onset and Death		
Immediate Cause (Final disease or condition resulting in death)		<i>Fatal Cardiac arrhythmia</i>		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		<p>a. Due to (or as a consequence of):</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
		<p>24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</p> <p>24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <i>D0053709</i>		
29b. Signature and title of certifier <i>Raj Chawla MD</i>		29d. Date signed (Month, Day, Year) <i>Feb 21st 2012</i>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		31. Date filed (Month, Day, Year) <i>FEB 23 2012</i>		
		32. Registrar's Signature <i>Suzanne S. Parker</i>		

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 0788

3. Time of Death

2. Date of Death
Month Day Year
FEBRUARY 21 2012 10:00PM

1- For State Registrar

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last)

ORVILLE WILLIS

4a. Facility Name (If not institution, give street and number)

Bayview Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

214-12-4949

6. Sex

 M F

7. Age (In yrs. last birthday)

93

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

8. Date of Birth

Hours

Min.

(Month, Day, Year)

Oct. 14, 1918

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Dorchester

10c. City, Town or Location

Cambridge

10d. Inside City Limits

 Yes No

10e. Street and Number

602 William Street

10f. Zip Code

21613

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Army
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No)
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 Yes No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

2

Mailman

16b. Kind of Business/Industry

U.S. Postal Service

17. Father's Name (First, Middle, Last)

Clarence Milton Willis

18. Mother's Name (First, Middle, Maiden Surname)

Estella Elizabeth Coppage

19a. Informant's Name/Relationship (Type, Print)

Bonnie Malkus/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8245 Stonecrop Dr., #K, Ellicott City, MD 21043

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Christ Church Cemetery 2-27-2012

Date

20c. Location - City or Town, State

Cambridge, Maryland

21. Signature of Funeral Service Licensee

D. K. Anand

22. Name and Address of Facility

Beall Funeral Home

6512 NW Crain Hwy, Bowie, Maryland 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

C. CARDIOPULMONARY ARREST.

a. Due to (or as a consequence of):

DEMENTIA

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No
9 Unknown23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown3 Ectopic pregnancy5 Other (specify)23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CORONARY ARTERY DISEASE, HYPERTENSION,
DEBILITY, FAILURE TO THRIVE, CEREBROVASCULAR
ACCIDENT.

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

25. Was case referred to medical examiner?

1 Yes 2 No

26. Place of Death (Check only one)

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 5 Pending investigation
2 Accident 3 Suicide 4 Homicide
6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

J. Kanwal, CLINICAL ASSOCIATE

MD

29c. License number

D711644

29d. Date signed (Month, Day, Year)

FEBRUARY 22nd 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KANWAL AWAN, MD. 5505 HOPKINS BAYVIEW CIRCLE, BALTIMORE, MD 21224

31. Date filed (Month, Day, Year)

FEB 23 2012

32. Registrar's Signature

Anuva P. Patel

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07882

1- For
State
Registrar

Physician/
Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death Hour Minute AM/PM	
Donald R. Winchell		02 16 2012		6:20 AM	
4a. Facility Name (if not institution, give street and number) Anne Arundel Medical Center		4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arundel	
5. Social Security Number 396-46-1046 Usual Residence of Decedent		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F 63 Yrs.		7. Age (In yrs. last birthday) If Under 1 Year Months Days Hours Min.	
10a. State Maryland		10b. County Queen Anne		10c. City, Town or Location Chester	
10e. Street and Number 5 G Queen Victoria Way		10f. Zip Code 21619		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates Viet Nam		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Operating Engineer		16b. Kind of Business/Industry Crane Operator	
17. Father's Name (First, Middle, Last) Oscar Winchell		18. Mother's Name (First, Middle, Maiden Surname) Helen Gavin			
19a. Informant's Name/Relationship (Type, Print) Linda Winchell/Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 G Queen Victoria Way, Chester, MD 21619			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Hillcrest Cemetery		Date 2/20/2012	20c. Location - City or Town, State Annapolis, Maryland
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037			
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part 2. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Small cell lung cancer			
23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	
		28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier 		29c. License number 052756		29d. Date signed (Month, Day, Year) 2/17/12	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Martin J. Parrot 405 Defense Hwy Annapolis MD 21401					
31. Date filed (Month, Day, Year) FEB 22 2012		32. Registrar's Signature Karen S. Parker			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07883

1-For State Registrar**Physician/
Medical Examiner****Funeral
Director****To Be Completed by Funeral Director****Baltimore, MD 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death 1145 hrs
Jason Lawrence Yeatts		February 28, 2012

4a. Facility Name (if not institution, give street and number) Baltimore Washington Medical Center	4b. City, Town, or Location of Death Glen Burnie	4c. County of Death Anne Arundel			
5. Social Security Number 218-13-4137	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 34 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (MM/DD/YYYY) 07/16/1977	9. Birthplace (State or Foreign Country) Maryland

10a. State Maryland	10b. County St. Mary's	10c. City, Town or Location Hollywood	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
------------------------	---------------------------	--	--

10e. Street and Number 25464 Allston Lane	10f. Zip Code 20636	10g. Citizen of What Country? United States
--	------------------------	--

11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: Specify: White	14. Race - American Indian, Black, White, etc.
--	---	---	--

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Carpet Installer	16b. Kind of Business/Industry Flooring
--	--	--

17. Father's Name (First, Middle, Last) Larry Edward Yeatts	18. Mother's Name (First, Middle, Maiden Surname) Ruth Lyndell Skeen
--	---

19a. Informant's Name/Relationship (Type, Print) Larry E. Yeatts/Father	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25464 Allston Lane, Hollywood, MD 20636
--	--

20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify: Edward N. Brinsfield, Jr. M00052	20b. Place of Disposition (Name of cemetery, crematory or other place) Brinsfield-Echols Cre	Date 03/02/2012	20c. Location - City or Town, State Charlotte Hall, MD
--	---	--------------------	---

21. Signature of Funeral Service Licensee Edward N. Brinsfield, Jr.	22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 20650
--	--

**Physician/
Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	a. Complications of Traumatic Rectal Perforation Due to (or as a consequence of):	Approximate Interval Between Onset and Death
--	---	--

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. _____ Due to (or as a consequence of):	
c. _____ Due to (or as a consequence of):		
d. _____ Due to (or as a consequence of):		

<input checked="" type="checkbox"/> UNPENDED	<input checked="" type="checkbox"/> AMENDED 23a, 27, 28a-f, per me, g931 9-6-12 sm 28e, per me, g932 10-22-12 sm	
--	---	--

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
--	---	---

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
	24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No

25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other:	26. Place of Death (Check only one)
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27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide	28a. Date of Injury 10/11/07 fd 11-9-07	28b. Time of Injury fd 04:48 am	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	28d. Describe how injury occurred Subject was assaulted
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	Single Family Home		
		28f. Location (Street and Number or Rural Route Number, City or Town, State) 24618 Horseshoe Rd. Clements, MD.		

29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29b. Signature and title of certifier <i>Pamela Southall, MD</i>	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) February 29, 2012
---	---	---------------------------------	--

30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223
--

31. Date filed (Month, Day, Year) MAR 02 2012	32. Registrar's Signature <i>James J. Parker</i>
---	---

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07884

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ROSEMARY TERESA ANDERSON							2. Date of Death Month Day Year 03 08 2012			3. Time of Death 11:30 AM	
	4a. Facility Name (If not institution, give street and number) 2121 WINDSOR GARDEN LANE			4b. City, Town, or Location of Death G-WYNN OAK BALTIMORE			4c. County of Death BALTIMORE					
Funeral Director	5. Social Security Number 214-44-4733		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 66 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 11-20-1945	9. Birthplace (State or Foreign Country) Maryland				
Usual Residence of Decedent 10a. State MD 10b. County MA 10c. City, Town or Location Baltimore, MD 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No												
10e. Street end Number 2121 Windsor Garden Lane Apt. Lane 10f. Zip Code 21207 10g. Citizen of What Country? USA												
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1966			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Black			14. Race - American Indian, Black, White, etc. Specify: Black				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)			Crane operator			16b. Kind of Business/Industry Construction				
17. Father's Name (First, Middle, Last) Oliver James Anderson		18. Mother's Name (First, Middle, Maiden Surname) Clara Elvira Brown										
19a. Informant's Name/Relationship (Type, Print) Wanda Marie STRICKLAND		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4284 Mary Ridge Drive Randallstown MD 21133										
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Ronald A. Grayson		20b. Place of Disposition (Name of cemetery, crematory or other place) King Memorial Park			Date Mar 13/2			20c. Location - City or Town, State Randallstown MD				
21. Signature of Funeral Service Licensee Ronald A. Grayson		22. Name and Address of Facility Ronald A. Grayson Funeral Service										
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. GRAND MAL SEIZURES								Approximate Interval Between Onset and Death				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Due to (or es a consequence of): b. DEMENTIA			Due to (or es a consequence of): c. HIGH BLOOD PRESSURE							
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown												
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) Residence										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) 28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred						
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) At home					28f. Location (Street and Number or Rural Route Number, City or Town, State) BALTIMORE MD					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier Nishia P. SOPREY M.D.		29c. License number Doe 24476			29d. Date signed (Month, Day, Year) 03-09-2012							
31. Date filed (Month, Day, Year) MAR 14 2012		32. Registrar's Signature Leanne J. Parker										

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tranit once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07885

1 - For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) MARCELLUS ANDERSON SR.			2. Date of Death Month MARCH Day 7 Year 2012	3. Time of Death 8:30 A M										
	4a. Facility Name (if not institution, give street and number) 2038 N ANVIL LANE			4b. City, Town, or Location of Death TEMPLE HILLS											
Funeral Director	5. Social Security Number 579-56-1148	6. Sex <input checked="" type="checkbox"/> X M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 69 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) AUGUST 22 1942	9. Birthplace (State or Foreign Country) WASHINGTON, DC								
	10a. State MD			10b. County PRINCE GEORGE'S			10c. City, Town or Location TEMPLE HILLS	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
To Be Completed by Funeral Director	10e. Street and Number 2038 N ANVIL LANE			10f. Zip Code 20748			10g. Citizen of What Country? USA								
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:								
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SUPERVISOR			16b. Kind of Business/Industry PRIVATE									
17. Father's Name (First, Middle, Last) WILLIAM J. ANDERSON				18. Mother's Name (First, Middle, Maiden Surname) LEAH LEWIS											
19a. Informant's Name/Relationship (Type, Print) GLORIA J. ANDERSON/WIFE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2038 N ANVIL LANE TEMPLE HILLS, MARYLAND 20748											
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Lincoln Cemetery			Date 3/19/2012	20c. Location - City or Town, State SUITLAND, MARYLAND								
21. Signature of Funeral Service Licensee Daphney N. Cornelius			22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785												
Physician/ Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)														
	<table border="1"> <tr> <td>a. Malignant NEOPHISM of Liver Due to (or as a consequence of):</td> <td>Approximate Interval Between Onset and Death Years</td> </tr> <tr> <td>b. Chronic hepatitis C Due to (or as a consequence of):</td> <td>Years</td> </tr> <tr> <td>c. _____ Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d. _____ Due to (or as a consequence of):</td> <td></td> </tr> </table>								a. Malignant NEOPHISM of Liver Due to (or as a consequence of):	Approximate Interval Between Onset and Death Years	b. Chronic hepatitis C Due to (or as a consequence of):	Years	c. _____ Due to (or as a consequence of):		d. _____ Due to (or as a consequence of):
a. Malignant NEOPHISM of Liver Due to (or as a consequence of):	Approximate Interval Between Onset and Death Years														
b. Chronic hepatitis C Due to (or as a consequence of):	Years														
c. _____ Due to (or as a consequence of):															
d. _____ Due to (or as a consequence of):															
Medical Certificate: To Be Completed by Physician/Medical Examiner	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year								
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown									
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			23f. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred									
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)												
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input checked="" type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. Signature and title of certifier ANP-BC			29c. License number AC0000937			29d. Date signed (Month, Day, Year) March 12, 2012									
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Melanie N Reynolds ANP-BC 9200 Basil Ct. Ste 200 Largo MD 20774															
31. Date filed (Month, Day, Year) MAR 14 2012			32. Registrar Signature [Signature]												

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07886

1- For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) William Norman Charles Archer							2. Date of Death Month Day Year MARCH 7, 2012	3. Time of Death 5:30A M	
	4a. Facility Name (if not institution, give street and number) Doctor's Community Hospital			4b. City, Town, or Location of Death Lanham			4c. County of Death Prince George's			
Funeral Director	5. Social Security Number 220-49-0892		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.		If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month/Day/Year) 05/29/1927	9. Birthplace (State or Foreign Country) England	
	Usual Residence of Decedent MD		10a. State MD		10b. County Prince George's		10c. City, Town or Location OXON HILL			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
To Be Completed by Funeral Director	10e. Street and Number 7903 Indian Head Hwy., Apt. 109				10f. Zip Code 20745			10g. Citizen of What Country? England		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 4		16b. Kind of Business/Industry Government Worker				
	17. Father's Name (First, Middle, Last) William Archer				18. Mother's Name (First, Middle, Maiden Surname) Coliss					
	19a. Informant's Name/Relationship (Type, Print) Julia Archer / Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7903 Indian Head Hwy., Apt. 109, Oxon Hill, MD 20745					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory			Date 3/12/2012	20c. Location - City or Town, State Beltsville, MD		
	21. Signature of Funeral Service Licensee Dorota Marshall			22. Name and Address of Facility Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203						
Physician/ Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PULMONARY EMBOLISM								Approximate Interval Between Onset and Death	
	b. Due to (or as a consequence of): DEEP VEIN THROMBOSIS LOWER EXTREMITY									
	c. Due to (or as a consequence of):									
	d. Due to (or as a consequence of):									
Physician/ Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year		
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I CHRONIC LYMPHOCYTIC LEUKEMIA ISCHEMIC CARDIOMYOPATHY								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
									24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA			Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	29b. Signature and title of certifier Babilah MD		29c. License number D66658		29d. Date signed (Month, Day, Year) 03/08/2012					
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rexford Babilah 9470 ANNAPOLIS ROAD, SUITE 306, LANHAM, MD 20706									
State Registrar	31. Date filed (Month, Day, Year) MAR 14 2012		32. Registrar's Signature Leanne B. Farrel							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM #26 per PHYS, G925, 3/14/2012, WS#31 per DVR

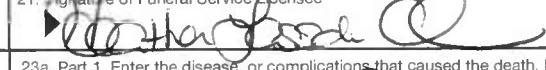
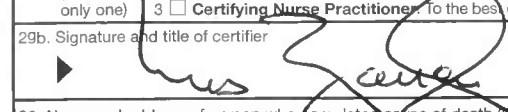
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07887

1 - For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Frances Irene Bach							2. Date of Death March 4, 2012	3. Time of Death 7:30p M	
	4a. Facility Name (if not institution, give street and number) Morningside Assisted Living			4b. City, Town, or Location of Death Parkville			4c. County of Death Baltimore			
Funeral Director	5. Social Security Number 217 40 7929	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 91	If Under 1 Year Months	If Under 24 Hrs. Days	Hours	Min.	8. Date of Birth (Month, Day, Year) November 15 1920	9. Birthplace (State or Foreign Country) Baltimore, Maryland	
	Usual Residence of Decedent Maryland Baltimore			10c. City, Town or Location Baltimore County					10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number 4210 Fitch Avenue				10f. Zip Code 21236			10g. Citizen of What Country? USA		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		
Physician/ Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) N/A			16b. Kind of Business/Industry Housewife		
	17. Father's Name (First, Middle, Last) Frank Desch				18. Mother's Name (First, Middle, Maiden Surname) Irene Jones					
Medical Certificate: To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) M. Diane Borlie				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4210 Fitch Avenue Baltimore, Maryland 21236					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Gardens of Faith Cem.			Date March 8, 2012	20c. Location - City or Town, State Baltimore, Maryland	
Medical Certificate: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Lassahn Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236					
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Coronary Artery disease				Approximate Interval Between Onset and Death					
Medical Certificate: To Be Completed by Physician/Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Coronary Artery disease				Approximate Interval Between Onset and Death					
	23b. Sequentially list conditions, if any, leading to the immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
Medical Certificate: To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year			
	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		23f. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic obstructive Pulmonary disease Charcot - Marie - Tooth				23g. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
Medical Certificate: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: Assisted Living		23h. Describe how injury occurred					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year) 28b. Time of injury M		28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
Medical Certificate: To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number DE054426		29d. Date signed (Month, Day, Year) MARCH 05 2012			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) michael ZANG 7602 Belair Rd Baltimore MD 21236		31. Date filed (Month, Day, Year) 3/5/2012		32. Registrar's Signature Laura S. Parker					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07888

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MURIEL D. BROWN							2. Date of Death Month Day Year MARCH 10 2012	3. Time of Death 6:50 A M
	4a. Facility Name (If not institution, give street and number) CRESCENT CITIES CENTER			4b. City, Town, or Location of Death RIVERDALE			4c. County of Death PRINCE GEORGE'S		
Funeral Director	5. Social Security Number 118-20-0706	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months <input type="checkbox"/>	If Under 24 Hrs. Days <input type="checkbox"/>	Hours <input type="checkbox"/>	Min. <input type="checkbox"/>	8. Date of Birth (Month, Day, Year) NOV. 28 1928	9. Birthplace (State or Foreign Country) NEW YORK
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State MD 10b. County PRINCE GEORGE'S 10c. City, Town or Location LANDOVER								10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number 7801 BARLOW ROAD #310				10f. Zip Code 20785			10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: Elementary/Secondary (0-12) 12TH			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: College (1-4 or 5+) CROSSING GUARD			14. Race - American Indian, Black, White, etc. Specify: BLACK	
	15. Decedent's Education (Specify only highest grade completed)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business/Industry GOVERNMENT	
	17. Father's Name (First, Middle, Last) WILLIAM BROWN				18. Mother's Name (First, Middle, Maiden Surname) JENNIE LEE MAXWELL				
	19a. Informant's Name/Relationship (Type, Print) SAMIA SALAAM-SALEH/SISTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3850 ENFIELD CHASE CT #321 BOWIE, MARYLAND 20716				
Physician /Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) RIVERDALE CREMATORY			Date 3/17/2012	20c. Location - City or Town, State RIVERDALE, MARYLAND	
Medical Certification: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Diane L. Calloway				22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Rectal Cancer Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
	<p>a. Due to (or as a consequence of): RECTAL CANCER</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
					28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier Sadia Husain M.D.				29c. License number 10064208			29d. Date signed (Month, Day, Year) MARCH 13, 2012	
State Registrar	31. Date filed (Month, Day, Year) MAR 14 2012				32. Registrar's Signature Sadia Husain				

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012

07889

1 - For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Keith Brittingham					2. Date of Death Month 3 Day 12 Year 2012	3. Time of Death 0907 M					
	4a. Facility Name (if not institution, give street and number) Peninsula Regional Medical Center					4b. City, Town, or Location of Death Salisbury		4c. County of Death Wicomico				
Funeral Director	5. Social Security Number unk		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (in yrs. last birthday) 57 Yrs.	If Under 1 Year Months 0 Days 0	If Under 24 Hrs. Hours 0 Min. 0	8. Date of Birth (Month, Day, Year) Aug 19, 1954	9. Birthplace (State or Foreign Country) unk				
	Usual Residence of Decedent		10a. State MD 10b. County Wicomico 10c. City, Town or Location Salisbury					10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
To Be Completed by Funeral Director	10e. Street and Number 527 Alabama Ave.					10f. Zip Code 21801		10g. Citizen of What Country? USA				
	11. Marital Status unk <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? unk <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unk			16a. Decedent's Usual Occupation unk (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business/Industry unk					
	17. Father's Name (First, Middle, Last) unk					18. Mother's Name (First, Middle, Maiden Surname) unk						
	19a. Informant's Name/Relationship (Type, Print) Peninsula Regional Medical Ctr.					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 100 E. Carroll St; Salisbury, MD 21801						
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) in state			20b. Place of Disposition (Name of cemetery, crematory or other place)		Date	20c. Location - City or Town, State					
	21. Signature of Funeral Service Licensee Ronald S. Wade, Director			22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201								
Physician Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ESRD								Approximate Interval Between Onset and Death			
Medical Certificate: To Be Completed by Physician/Medical Examiner	a. Due to (or as a consequence of): Sepsis											
	b. Due to (or as a consequence of): AS CVD											
	c. Due to (or as a consequence of): 											
	d. 											
IF FEMALE:	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown								23d. Date of delivery Month 0 Day 0 Year 0			
Medical Certificate: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								26. Place of Death (Check only one) <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide								28a. Date of injury (Month, Day, Year) 08/19/2012	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State) 100 E. Carroll St; Salisbury, MD 21801			
	29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								29b. Signature and title of certifier SGRATHY		29c. License number 773353	29d. Date signed (Month, Day, Year) MARCH 4, 2012
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SGRATHY Pataparia, M.D. 100 E. Carroll St. SALISBURY, MD											
State Registrar	31. Date filed (Month, Day, Year) MAR 14 2012								32. Registrar's Signature SGRATHY P. Pataparia			

Baltimore, Maryland 21215-0036

Permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

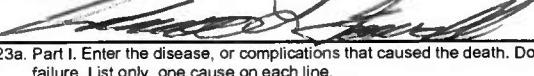
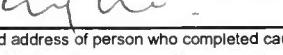
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07890

Physician/ Medical Examiner		Registrar						Date of Death Month Day Year		3. Time of Death 1947 hrs							
		RONNIE BELL						March 8, 2012									
Funeral Director		4a. Facility Name (if not institution, give street and number) Union Memorial Hospital				4b. City, Town, or Location of Death Baltimore				4c. County of Death N/A							
		5. Social Security Number 212-56-8351		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 61 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (MM/DD/YYYY) 12/28/1950	9. Birthplace (State or Foreign Country) W. VIRGINIA								
To Be Completed by Funeral Director		Usual Residence of Decedent MD N/A		10c. City, Town or Location BALTIMORE						10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
		10a. State MD		10b. County N/A		10e. Street and Number 3678 FALLS ROAD APT. 2						10f. Zip Code 21211		10g. Citizen of What Country? U.S.A.			
To Be Completed by Funeral Director		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify:				14. Race - American Indian, Black, White, etc. Specify: WHITE							
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 1 PLUMBING				16b. Kind of Business/Industry CONSTRUCTION							
To Be Completed by Physician/Medical Examiner		17. Father's Name (First, Middle, Last) JOSEPH LEE BELL				18. Mother's Name (First, Middle, Maiden Surname) PEARL JANE GROSE											
		19a. Informant's Name/Relationship (Type, Print) ANGEL BELL / DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 528 S. LAKEWOOD AVENUE, BALTIMORE, MD 21224											
To Be Completed by Physician/Medical Examiner		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:		20b. Place of Disposition (Name of cemetery, crematory or other place) BAYVIEW CREMATORY		Date 3/17/12	20c. Location - City or Town, State BALTIMORE, MD										
		21. Signature of Funeral Service Licensee 		22. Name and Address of Facility LILLY & ZEILER INC. FUNERAL HOME 700 S. CONKLING STREET, BALTIMORE, MD													
To Be Completed by Physician/Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. <input type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED										Approximate Interval Between Onset and Death					
		23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) _____ 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year									
To Be Completed by Physician/Medical Examiner		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown															
		23f. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		23g. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No													
To Be Completed by Physician/Medical Examiner		24. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other:															
		25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		27a. Date of Injury (Month, Day, Year)		28a. Time of Injury		28c. Injury at Work?		28d. Describe how injury occurred					
To Be Completed by Physician/Medical Examiner		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)													
		29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) March 9, 2012									
To Be Completed by Physician/Medical Examiner		30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223															
		31. Date filed (Month, Day, Year) MAR 14 2012		32. Registrar's Signature 													
State Registrar																	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07891

1 For
State
Registrar

Physician/
Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

Physician/
Medical
Examiner

State
Registrar

1. Decedent's Name (First, Middle, Last) Alexander J Brown			2. Date of Death Month March Day 4 Year 2012		3. Time of Death 8:45P M
4a. Facility Name (if not institution, give street and number) Seasons Hospice			4b. City, Town, or Location of Death Randallstown		4c. County of Death Baltimore
5. Social Security Number 212-61-0668		6. Sex 1X M 2 F	7. Age (In yrs. last birthday) 98 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 01 01 14
9. Usual Residence of Decedent MD		10a. State Montgomery		10b. County Silver Spring	
10c. City, Town or Location Silver Spring			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 9 Balboa Ct.			10f. Zip Code 20905		10g. Citizen of What Country? U.S.A.
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Black	
14. Race - American Indian, Black, White, etc. Black					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th grade			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) na Cigas Manufacturer		16b. Kind of Business/Industry Self Employed
17. Father's Name (First, Middle, Last) Joseph Brown			18. Mother's Name (First, Middle, Maiden Surname) Mariah Dryden		
19a. Informant's Name/Relationship (Type, Print) Evelyn Watson-Daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Balboa Ct., Silver Spring, Md 20905		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Woodlawn		Date 3/17/2012	20c. Location - City or Town, State Woodlawn, Md
21. Signature of Funeral Service Licensee ► Alynes B. Keke			22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21215		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Atherosclerotic cardiovascular disease					
Approximate Interval Between Onset and Death					
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
<p>a. Due to (or as a consequence of): Atherosclerotic cardiovascular disease</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>					
IF FEMALE:		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) Hospital		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year) 28b. Time of injury M		28c. Injury at work? 1 <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) At home					
28f. Location (Street and Number or Rural Route Number, City or Town, State) Baltimore MD 21209					
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier ► N S Rayapati MD			
29c. License number DOOS7U65				29d. Date signed (Month, Day, Year) 3/17/12	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N S Rayapati MD 2835 Smith St 703					
31. Date filed (Month, Day, Year) MAR 14 2012			32. Registrar's Signature Sandra J. Parker		

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07892

1- For State Registrar**Physician/
Medical Examiner**

1. Decedent's Name (First, Middle, Last) Nancy Breeding	2. Date of Death Month February Day 19 Year 2012	3. Time of Death 1045 hrs
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Funeral Director

4a. Facility Name (if not institution, give street and number) 1240 W. Lombard Street	4b. City, Town, or Location of Death Baltimore	4c. County of Death				
5. Social Security Number 141-66-0078	6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 49 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (MM/DD/YYYY) 07/22/1962	9. Birthplace (State or Foreign Country) N.J

To Be Completed by Funeral Director

20046

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, MD 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

10a. State MD	10b. County	10c. City, Town or Location Baltimore	10d. Inside City Limits 1 Yes 2 No
10e. Street and Number 4101 Old York Road		10f. Zip Code 21223	10g. Citizen of What Country? USA

11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify:	14. Race - American Indian, Black, White, etc. Specify: White
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced	If Yes, Give Year of Dates:		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)	College (1-4 or 5+) 2yrs	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nurse	16b. Kind of Business/Industry Health

17. Father's Name (First, Middle, Last) John Twombly	18. Mother's Name (First, Middle, Maiden Surname) Marion McCarty
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19a. Informant's Name/Relationship (Type, Print) Heather Twombly	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2675 Wilkens Ave Baltimore MD 21223		
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State	20b. Place of Disposition (Name of cemetery, crematory or other place) Atlantic Crem	Date 03/08/12	20c. Location - City or Town, State Glen Burnie MD
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:			

21. Signature of Funeral Service Licensee <i>Thomas Allen PA</i>	22. Name and Address of Facility Simplicity Crem & Fun Serv ThomasAllenPA 7090 Ridge Rd Hanover MD
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**Physician/
Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Narcotic (morphine) intoxication complicated by Atherosclerotic Cardiovascular Disease	Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	
a. Due to (or as a consequence of):	
b.	
c.	
d.	
<input checked="" type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED	23a,27,28a-f per me g925 3-28-12 vt

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
	24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No

25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	26 Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> D.O.A Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene
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27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input checked="" type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day, Year) fd 2-19-12	28b. Time of Injury fd 10:36am	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	28d. Describe how injury occurred unknown
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) found in vacant building	28f. Location (Street and Number or Rural Route Number, City or Town, State) 1240 N. Lombard St. Baltimore, Md.		

29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29b. Signature and title of certifier <i>D. M. Vincenti</i>	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) February 20, 2012
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30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223
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31. Date filed (Month, Day, Year) MAR 14 2012	32. Registrar's Signature <i>James J. Parker</i>
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07893

1- For State RegistrarPhysician/
Medical ExaminerFuneral
Director**To Be Completed by Funeral Director**

Important: If item 27 is marked after than "natural", or items 23 or 28a-f have any injury or other traumatic event, the Medical Examiner must be notified at once.
 Baltimore, MD 21215-0036
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

1. Decedent's Name (First, Middle, Last)	Date Brown			2. Date of Death Month Day Year March 11, 2012	3. Time of Death 2126 hrs
4a. Facility Name (if not institution, give street and number) Bon Secours Hospital	4b. City, Town, or Location of Death Baltimore			4c. County of Death N/A	
5. Social Security Number 219-74-9572	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 53	If Under 1 Year Months Days Hours Min.	8. Date of Birth (MM/DD/YYYY) 12-14-1958	
10a. State Md.	10b. County N/A	10c. City, Town or Location Baltimore	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 2603 W. Fairmount Ave	10f. Zip Code 21223			10g. Citizen of What Country? USA	
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married	12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify:	14. Race - American Indian, Black, White, etc. Specify: BLACK		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th	College (1-4 or 5+) N/A	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Construction Worker	16b. Kind of Business/Industry Construction		
17. Father's Name (First, Middle, Last) Charles Anderson	18. Mother's Name (First, Middle, Maiden Surname) Margaret Jones				
19a. Informant's Name/Relationship (Type, Print) Eileen Moulton	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2608 Roslyn Ave. Balt., md. 21216				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify: Signature of Funeral Service Licensee Dacey M. Wallace	20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Cemetery	Date 3-17-12	20c. Location - City or Town, State Catonsville, MD		
21a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	a. Narcotic Intoxication and Cocaine Use Due to (or as a consequence of):				
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	Due to (or as a consequence of):			
c.	Due to (or as a consequence of):				
d.					
<input checked="" type="checkbox"/> UNPENDED	<input type="checkbox"/> AMENDED 23a,27,28a-f per me g925 3-28-12 vt				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
					24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
					24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other:				
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input checked="" type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day, Year) Ed 3-11-12	28b. Time of Injury fd 8:35pm	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	28d. Describe how injury occurred unknown	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) residence					28f. Location (Street and Number or Rural Route Number, City or Town, State) 2603 W. Fairmount Ave Baltimore, Md.
29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier Theodore M. King, Jr., MD.	29c. License number O.C.M.E. OCME			29d. Date signed (Month, Day, Year) March 12, 2012	
31. Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223					
32. Date filed (Month, Day, Year) MAR 14 2012	32. Registrar's Signature Laura J. Parker				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2012 07894

1- For State
Registrar

Reg. No.

**Physician/
Medical Examiner**

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death 1410 hrs
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4a. Facility Name (if not institution, give street and number) Union Memorial Hospital	4b. City, Town, or Location of Death Baltimore	4c. County of Death
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**Funeral
Director**

5. Social Security Number	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 34 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (MM/DD/YYYY) 1/10/1978	9. Birthplace (State or Foreign Country) MD
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Usual Residence of Decedent
10a. State MD
10b. County N/A
10c. City, Town or Location Baltimore
10e. Street end Number 5003 Corley Road Apt A-2
10f. Zip Code 21207
10g. Citizen of What Country? USA
10d. Inside City Limits Yes No

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: Specify: Black	14. Race - American Indian, Black, White, etc.
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15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12	16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 0 Package Goods Store	16b. Kind of Business/Industry Self-Employed
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17. Father's Name (First, Middle, Last) Rodney Brewington	18. Mother's Name (First, Middle, Maiden Surname) Ronia Jefferson
--	--

19a. Informant's Name/Relationship (Type, Print) Ms. Ronia Johnson	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5003 Corley Rd. Apt A-2 Balt., MD 21207
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20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify: Telle H. Harris, L.M.	20b. Place of Disposition (Name of cemetery, crematory or other place) King Memorial Park	Date 3/9/2012	20c. Location - City or Town, State Woodlawn, MD
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21. Signature of Funeral Service Licensee Telle H. Harris, L.M.	22. Name and Address of Facility Joseph L. Russ Funeral Home, P.A. 221 N. North Ave. Balt., MD 21216
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Baltimore, MD 21215-0036**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

**Physician/
Medical Examiner****Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and Death
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Immediate Cause (Final disease or condition resulting in death) a. <i>Neisseria meningitidis sepsis</i> Due to (or as a consequence of):	
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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of):	
--	--

c. Due to (or as a consequence of):	
--	--

d. Due to (or as a consequence of):	
--	--

<input checked="" type="checkbox"/> UNPENDED	<input checked="" type="checkbox"/> AMENDED #1,23a,27,per me,g928 6-11-12 sm
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IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
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	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
--	--

25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other:
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27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
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	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
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28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
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29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29d. Date signed (Month, Day, Year) March 3, 2012
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29b. Signature and title of certifier Ana Rubio MD.	29c. License number O.C.M.E.
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30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	31. Date filed (Month, Day, Year) MAR 14 2012	32. Registrar's Signature Lewes J. Parker
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**State
Registrar**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 0789

1. For State Registrar

1. Decedent's Name (First, Middle, Last)

GARY EDWARD BINDOK

2. Date of Death

Month Day Year
March 10, 2012

3. Time of Death

2350 hrs

Physician/
Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Baltimore, MD 21215-0036
 Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
 Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23 or 24-a-f show any
 injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
 within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and
 completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

1. For State Registrar		1. Decedent's Name (First, Middle, Last) GARY EDWARD BINDOK						2. Date of Death Month Day Year March 10, 2012		3. Time of Death 2350 hrs					
4a. Facility Name (if not institution, give street and number) 8336 Kendale Road		4b. City, Town, or Location of Death Parkville						4c. County of Death Baltimore County							
5. Social Security Number 216-94-2610		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 48 Yrs.		If Under 1 Year Months Days Hours Min.		8. Date of Birth (MM/DD/YYYY) 2/3/1964		9. Birthplace (State or Foreign Country) MARYLAND					
10a. State MD		10b. County BALTIMORE		10c. City, Town or Location PARKVILLE						10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
10e. Street and Number 8336 KENDALE ROAD						10f. Zip Code 21234				10g. Citizen of What Country? USA					
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: WHITE			14. Race - American Indian, Black, White, etc. WHITE						
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 5 + YEARS FINANCIAL ANALYST			16b. Kind of Business/Industry PHARMACEUTICAL CO.									
17. Father's Name (First, Middle, Last) DONALD E. BINDOK/FATHER						18. Mother's Name (First, Middle, Maiden Surname) SUSAN M. MILLER									
19a. Informant's Name/Relationship (Type, Print) DONALD E. BINDOK/FATHER						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8140 KIRKWALL COURT TOWSON, MD 21286									
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State			20b. Place of Disposition (Name of cemetery, crematory or other place) METRO CREMATORIAL, INC.			Date 3/17/2012		20c. Location - City or Town, State CATONSVILLE, MD							
21. Signature of Funeral Service Licensee Health Day - Johnson			MO1139			22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286									
23. Part I. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.															
Immediate Cause (Final disease or condition resulting in death) a. <u>Ruptured Myocardial Infarction</u> Due to (or as a consequence of):															
b. <u>Atherosclerotic Cardiovascular Disease</u> Due to (or as a consequence of):															
c. _____ Due to (or as a consequence of):															
d. _____															
<input type="checkbox"/> UNPENDED		<input type="checkbox"/> AMENDED										Approximate Interval Between Onset and Death			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown						23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
												24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene													
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred							
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)													
29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. one 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.															
29b. Signature and title of certifier D. J. Vincenti						29c. License number O.C.M.E.				29d. Date signed (Month, Day, Year) March 11, 2012					
30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223															
31. Date filed (Month, Day, Year) MAR 14 2012		32. Registrar's Signature Leanne A. Parker													

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07896

**1 - For
State
Registrar**

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) Leona Williams Cavanaugh								2. Date of Death Month March Day 10 Year 2012		3. Time of Death 8:10 A.M.	
		4a. Facility Name (if not institution, give street and number) Heartlands Senior Assisted Living				4b. City, Town, or Location of Death Ellicott City				4c. County of Death Howard			
Funeral Director		5. Social Security Number 214-24-7666		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 93 Yrs.		If Under 1 Year Months Days Hours Min. 		8. Date of Birth Month July Day 21 Year 1918		9. Birthplace (State or Foreign Country) South Carolina	
To Be Completed by Funeral Director		10a. State MD		10b. County Howard		10c. City, Town or Location Ellicott City						10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner		10e. Street and Number 3004 N. Ridge Road				10f. Zip Code 21043				10g. Citizen of What Country? USA			
Physician/ Medical Examiner		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White					
Medical Certificate: To Be Completed by Physician/Medical Examiner		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry Registered Nurse Medical							
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		17. Father's Name (First, Middle, Last) Richard Williams				18. Mother's Name (First, Middle, Maiden Surname) Alberta Richardson							
Medical Certificate: To Be Completed by Physician/Medical Examiner		19a. Informant's Name/Relationship (Type, Print) Michael Cavanaugh Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2078 Misty Meadow Road; Finksburg, MD 21048									
Physician/ Medical Examiner		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) MSK Hulse MOIOSD		20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Mem. Park		Date 3/14/2012		20c. Location - City or Town, State Elkridge, MD					
Medical Certificate: To Be Completed by Physician/Medical Examiner		21. Signature of Funeral Service Licensee MSK Hulse MOIOSD				22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228							
Physician/ Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)				Approximate Interval Between Onset and Death							
Medical Certificate: To Be Completed by Physician/Medical Examiner		b. Due to (or as a consequence of): Debility Due to (or as a consequence of):											
Physician/ Medical Examiner		c. Due to (or as a consequence of):											
Medical Certificate: To Be Completed by Physician/Medical Examiner		d. Due to (or as a consequence of):											
Physician/ Medical Examiner		23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year 							
Medical Certificate: To Be Completed by Physician/Medical Examiner		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
Physician/ Medical Examiner		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Assisted Living							
Medical Certificate: To Be Completed by Physician/Medical Examiner		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year) 		28b. Time of injury M		28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred 			
Medical Certificate: To Be Completed by Physician/Medical Examiner		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
Physician/ Medical Examiner		29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
Medical Certificate: To Be Completed by Physician/Medical Examiner		29b. Signature and title of certifier Andrew Lazarus				29c. License number D47447				29d. Date signed (Month, Day, Year) March 12, 2012			
Medical Certificate: To Be Completed by Physician/Medical Examiner		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrew Lazarus, 6334 Cedar Lane #103, Columbia, MD 21044											
State Registrar		31. Date filed (Month, Day, Year) MAR 14 2012		32. Registrar's Signature Leona B. Parker									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07897

1- For
State
Registrar

Physician/
Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Thomas Radcliffe Cheek, Sr.

2. Date of Death

Month March Day 11, Year 2012

3. Time of Death

5:13 A. M.

Funeral
Director

4a. Facility Name (if not institution, give street and number)

Catonsville Commons

4b. City, Town, or Location of Death

Catonsville

4c. County of Death

Baltimore

5. Social Security Number

219-32-7977

6. Sex

M

F

7. Age (In yrs. last birthday)

76

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

April 10, 1935

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

Yes No

10e. Street and Number

12 Bloomingdale Avenue

10f. Zip Code

21228

10g. Citizen of What Country?

USA

11. Marital Status

Never Married Married
 Widowed Divorced

12. Was Decedent Ever in U.S. Armed Forces?

Yes No
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Yes No Specify:

14. Race - American Indian, Black, White, etc.
Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) 12

College (1-4 or 5+) Master Plumber

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

Plumbing

17. Father's Name (First, Middle, Last)

Walter Marrow Cheek, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Frances N. Radcliffe

19a. Informant's Name/Relationship (Type, Print)

Barbara Cheek Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12 Bloomingdale Avenue; Catonsville, MD 21228

20a. Method of Disposition

Burial Cremation Removal from State
 Donation Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Atlantic Crematory

Date

3/12/2012

20c. Location - City or Town, State

Glen Burnie, MD

21. Signature of Funeral Service Licensee

► Mdg m01234

22. Name and Address of Facility

Sterling Ashton Schwab Witzke
Funeral Home of Catonsville, Inc.
1630 Edmondson Avenue; Catonsville, MD 21228

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Ischaemic cardiologyopathy

Approximate Interval Between Onset and Death

7 years

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 9 Unknown

23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (Specify)
9 Unknown

23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

25. Was case referred to medical examiner?
1 Yes 2 No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 5 Pending Investigation
2 Accident 6 Could not be determined
3 Suicide
4 Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?
1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)

2 Medical Examiner

3 Certifying Nurse Practitioner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

only one

3 Certifying Physician

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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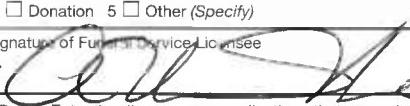
only one

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07898

1 For
State
RegistrarPhysician/
Medical
Examiner1. Decedent's Name (First, Middle, Last)
Mary Frances Chellis2. Date of Death
Month: March Day: 12 Year: 20123. Time of Death
1:45 P M4a. Facility Name (if not institution, give street and number)
Stella Maris Hospice4b. City, Town, or Location of Death
Timonium4c. County of Death
BaltimoreFuneral
Director5. Social Security Number
189-18-89506. Sex
1 M 2 F7. Age (In yrs. last birthday)
91 Yrs.If Under 1 Year
Months Days Hours Min.8. Date of Birth
(Month, Day, Year)
March 1, 19219. Birthplace (State or Foreign
Country)
Pennsylvania10a. State
MD10b. County
Wyoming10c. City, Town or Location
Tunkhannock10d. Inside City Limits
1 Yes 2 No10e. Street and Number
61 Keelersburg Road10f. Zip Code
1865710g. Citizen of What Country?
USA11. Marital Status
**1 Never Married 2 Married
3 Widowed 4 Divorced**12. Was Decedent Ever in U.S.
Armed Forces?
**1 Yes 2 No
If Yes, Give Year or Dates.**13. Was Decedent of Hispanic Origin? (Specify Yes or No.
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 Yes 2 No Specify:14. Race - American Indian,
Black, White, etc.
White15. Decedent's Education
(Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
Seamstress16b. Kind of Business/Industry
Ladies Garments17. Father's Name (First, Middle, Last)
Michael Wiernusz18. Mother's Name (First, Middle, Maiden Surname)
Frances Mary Rokus19a. Informant's Name/Relationship (Type, Print)
Charles Chellis Son19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8428 Dogwood Road; Windsor Mill, MD 2124420a. Method of Disposition
**1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)**20b. Place of Disposition (Name of
cemetery, crematory or other place)
Mt. Carmel CemeteryDate
3/16/201220c. Location - City or Town, State
Tunkhannock, PA21. Signature of Funeral Service Licensee
22. Name and Address of Facility
**Sterling Ashton Schwab Witzke
Funeral Home of Catonsville, Inc.
1630 Edmondson Avenue; Catonsville, MD 21228**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)Approximate
Interval Between
Onset and Death

END STAGE CARDIOMYOPATHY

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

d.

IF FEMALE:
23b. Was decedent pregnant
in the past 12 months?
**1 Yes 2 No
9 Unknown**23c. If yes, outcome of pregnancy
**1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify)
9 Unknown**23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?
1 Yes 2 No 3 Probably 4 Unknown24a. Was an autopsy performed?
1 Yes 2 No24b. Were autopsy findings available
prior to completion of cause of
death?
1 Yes 2 No25. Was case referred to medical
examiner?
1 Yes 2 No26. Place of Death (Check only one)
Hospital: **1 Inpatient 2 ER/Outpatient 3 DOA** Other: **4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE**27. Manner of Death
**1 Natural 5 Pending
2 Accident 6 Investigation
3 Suicide 7 Could not be
4 Homicide determined**28a. Date of injury
(Month, Day, Year)
M28b. Time of
injury
M28c. Injury at
work?
1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
**1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.**29b. Signature and title of certifier
29c. License number
**R130272
DEA # MSO 71158**29d. Date signed (Month, Day, Year)
3/12/1230. Name and address of person who completed cause of death (Item 23a) (Type, Print)
TRACIE L. MORGAN, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 2109331. Date filed (Month, Day, Year)
MAR 14 201232. Registrar's Signature


MARCH 12, 2012 1:45 p.m.

MARY CHELLIS

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland
Department. If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.State
Registrar

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.
amend #1& #16b&17 Per FH G925 3/26/2012 JH

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07899

1- For
State
Registrar

Physician/
Medical
Examiner

		1. Decedent's Name (First, Middle, Last)		Hickmon Hickmon	2. Date of Death	3. Time of Death			
		John		Carrington	Month	Day	Year	6:15 P M	
4a. Facility Name (if not institution, give street and number)		St. Agnes Hospital		4b. City, Town, or Location of Death		4c. County of Death			
5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)		
246-12-0221		1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	86 Yrs.			05 01 25	NC		
Usual Residence of Deceased									
10a. State		10b. County		10c. City, Town or Location		10d. Inside City Limits			
MD		NA		Baltimore		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number				10f. Zip Code		10g. Citizen of What Country?			
2726 North Longwood Street				21216		U.S.A.			
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black			
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced									
15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry					
Elementary/Secondary (0-12) 10th grade		College (1-4 or 5+) na		Butcher		Esskay Eckey Company			
17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)							
Hickmon Hickmon Carrington						Bessie Walker			
19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)		21216					
Lillie Carrington-Wife		2726 North Longwood Street, Baltimore, Md							
20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date	20c. Location - City or Town, State				
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		Loudon Park		3/17/2012	Baltimore, Md				
21. Signature of Funeral Service Licensee		22. Name and Address of Facility							
▶ Stephen B. Keke		March F/H West 4300 Wabash Ave, Baltimore, Md 21215							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23c. If yes, outcome of pregnancy		23d. Date of delivery			
				1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		Month	Day	Year	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
{		a. Due to (or as a consequence of): Hypotensive Shock				Approximate Interval Between Onset and Death 3 days			
b. Due to (or as a consequence of): Spontaneous Retroperitoneal Hemorrhage						3 days			
c. Due to (or as a consequence of): d. Due to (or as a consequence of):									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy		23d. Date of delivery					
		1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		Month	Day	Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death?					
				1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one)		27. Manner of Death		28a. Date of injury (Month, Day, Year)			
		Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28b. Time of injury M		28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
								28d. Describe how injury occurred	
								28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
								28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one)		1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier				29c. License number		29d. Date signed (Month, Day, Year)			
▶		MD		N11:1356659031		March 11, 2012			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		Thomas Buddensick		900 Caton Ave Baltimore MD 21229					
31. Date filed (Month, Day, Year)		32. Registrar's Signature							
MAR 14 2012		Seneca S. Parker							

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

Carrington, John

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07900

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) Susan Jane Conway						2. Date of Death Month: March Day: 10 Year: 2012	3. Time of Death 02:55PM M						
Funeral Director		4a. Facility Name (if not institution, give street and number) Peninsula Regional Medical Center			4b. City, Town, or Location of Death Salisbury			4c. County of Death Wicomico							
To Be Completed by Funeral Director		5. Social Security Number 578-60-7162		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 66 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month/Day/Year) 06/22/1945	9. Birthplace (State or Foreign Country) Washington DC						
To Be Completed by Funeral Director		10a. State MD		10b. County Wicomico		10c. City, Town or Location Salisbury			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						
To Be Completed by Physician/Medical Examiner		10e. Street and Number 108 Eastern Avenue				10f. Zip Code 21804			10g. Citizen of What Country? USA						
Physician/ Medical Examiner		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 2X		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White						
Medical Certificate: To Be Completed by Physician/Medical Examiner		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Executive Assistant		16b. Kind of Business/Industry Telecommunications									
Physician/ Medical Examiner		17. Father's Name (First, Middle, Last) John Cruit				18. Mother's Name (First, Middle, Maiden Surname) Virginia Gray									
Medical Certificate: To Be Completed by Physician/Medical Examiner		19a. Informant's Name/Relationship (Type, Print) Joan Ellen Conway / Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8421 Cinnamon Hill Avenue, Las Vegas, NV 89129									
Physician/ Medical Examiner		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) Dorota Marshall		20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory		Date 3/14/2012	20c. Location - City or Town, State Beltsville, MD								
Medical Certificate: To Be Completed by Physician/Medical Examiner		21. Signature of Funeral Service Licensee Dorota Marshall		22. Name and Address of Facility Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203											
Physician/ Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ASCENDANT ADULTIC ANEURYSM Due to (or as a consequence of): ACUTE DISSECTION Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):									Approximate Interval Between Onset and Death WRECS				
Medical Certificate: To Be Completed by Physician/Medical Examiner		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____						23d. Date of delivery Month Day Year					
Medical Certificate: To Be Completed by Physician/Medical Examiner		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PULMONARY EMBOLISM METASTATIC BREAST CANCER									23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				
Medical Certificate: To Be Completed by Physician/Medical Examiner		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							23f. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
Medical Certificate: To Be Completed by Physician/Medical Examiner		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred			24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
Medical Certificate: To Be Completed by Physician/Medical Examiner											24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
Medical Certificate: To Be Completed by Physician/Medical Examiner		29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier JAMES T. TODD MD							29c. License number D64884		29d. Date signed (Month, Day, Year) MAR 12, 2012		
Medical Certificate: To Be Completed by Physician/Medical Examiner		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JAMES T. TODD MD 100 E. Carroll St., Salisbury, MD													
Medical Certificate: To Be Completed by Physician/Medical Examiner		31. Date filed (Month, Day, Year) MAR 14 2012		32. Registrar's Signature James T. Todd											

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial and transit

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

**Physician/
Medical
Examiner**

Medical Certificate: To Be Completed by Physician/Medical Examiner

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend 20b-c, per fh,g925 3-14-12 sm

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 17901
3. Time of Death
5:58 A M

1 - For State Registrar

Physician/
Medical
Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month 03 Day 11 Year 2012				3. Time of Death 5:58 A M
BEATRICE CALLAGY							
4a. Facility Name (if not institution, give street and number) Gilchrist Center - Howard County			4b. City, Town, or Location of Death Columbia				4c. County of Death Howard

Funeral
Director

5. Social Security Number 112-24-9611		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 78 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) 03/07/1934	9. Birthplace (State or Foreign Country) New York
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Usual Residence of Decedent

10a. State
MD

10b. County
Howard

10c. City, Town or Location
LAUREL

10d. Inside City Limits
 Yes No

10e. Street and Number 9200 Brewington Lane			10f. Zip Code 20723	10g. Citizen of What Country? USA			
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11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: White			
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15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Secretary	16b. Kind of Business/Industry Education			
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17. Father's Name (First, Middle, Last) Joseph Petruccelli			18. Mother's Name (First, Middle, Maiden Surname) BENEDETTA SCLVAGGI				
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19a. Informant's Name/Relationship (Type, Print) John Callagy / Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 878 Greenlawn Ave.; Islip Terrace, NY 11752			20c. Location - City or Town, State Calverton, NY Farmingdale, NY		
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20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Calverton National Cemetery St. Charles Cemetery			Date 3/16/2012	20c. Location - City or Town, State Calverton, NY Farmingdale, NY	
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21. Signature of Funeral Service Licensee MOO217		22. Name and Address of Facility The Johnson Funeral Home, P.A. 8521 Loch Raven Blvd., Towson, MD 21286					
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23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death years					
<p>a. <i>Lung Cancer</i> Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>							
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Breast Cancer</i>						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
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23f. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <i>Hospice</i>			23g. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
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27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred		
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29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)	
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29b. Signature and title of certifier <i>B. J. Joseph</i>		29c. License number D0060634			29d. Date signed (Month, Day, Year) 3/11/12		
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>BINOU JOSEPH, 6336 CEDAR LANE, COLUMBIA, MD 21044</i>		31. Date filed (Month, Day, Year) MAR 14 2012					
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32. Registrar's Signature
J. Joseph

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Physician/
Medical
Examiner

15 ✓

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07902

1 - For
State
Registrar

**Physician/
Medical
Examiner**

**Funeral
Director**

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) SHARON E. DOBBS			2. Date of Death Month MARCH Day 8 , Year 2012	3. Time of Death 5:50 pM
4a. Facility Name (if not institution, give street and number) 13901 CASTLE BLVD. #11			4b. City, Town, or Location of Death SILVER SPRING	
4c. County of Death MONTGOMERY				
5. Social Security Number 579-78-4274		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 56 Yrs.	If Under 1 Year Months Days Hours Min.
8. Date of Birth (Month, Day, Year) SEPT 6, 1955		9. Birthplace (State or Foreign Country) WASHINGTON, DC		
10a. State MARYLAND		10b. County MONTGOMERY		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number 13901 CASTLE BLVD. #11			10f. Zip Code 20904	10g. Citizen of What Country? UNITED STATES
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: NATIVE AMERICAN	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11TH		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER		16b. Kind of Business/Industry PRIVATE
17. Father's Name (First, Middle, Last) UNKNOWN			18. Mother's Name (First, Middle, Maiden Surname) LORENE BROWN	
19a. Informant's Name/Relationship (Type, Print) JOHANNA DOBBS / DAUGHTER			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 103 G STREET, SW, UNIT 614B WASHINGTON, DC 20024	
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) RIVERDALE CREMATORY	Date 03/11/2012
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility JB JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD, HYATTSVILLE, MARYLAND 20785	
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)			Approximate Interval Between Onset and Death	
<p>a. Due to (or as a consequence of):</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		
23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>diabetes</i> <i>high cholesterol</i> <i>hypertension</i>				
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number 39018		
29b. Signature and title of certifier Betsy Ballard, M.D.		29d. Date signed (Month, Day, Year) MARCH 9, 2012		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BETSY BALLARD, M.D. 10301 GEORGIA AVENUE, SUITE 104, SILVER SPRING, MD 20902				
31. Date filed (Month, Day, Year) MAR 14 2012		32. Registrar's Signature 		

**State
Registrar**

Jesse Robert Duffy

12-01952

Unk Unk

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07903

1. For State Registrar**Physician Medical Examiner**

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death 0030 hrs
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JESSE ROBERT DUFFY

March 8, 2012

Month Day Year

4a. Facility Name (if not institution, give street and number) 1018 Cape Splitt Harbour	4b. City, Town, or Location of Death Riviera Beach	4c. County of Death Anne Arundel
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Funeral Director

5. Social Security Number 217-98-9903	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 30 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (MM/DD/YYYY) 4-4-81	9. Birthplace (State or Foreign Country) MD.
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10a. State MD	10b. County ANNE ARUNDEL	10c. City, Town or Location PASADENA	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
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10e. Street and Number 339 CAMBRIDGE RD.	10f. Zip Code 21122	10g. Citizen of What Country? U.S.A.
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11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: Specify WHITE	14. Race - American Indian, Black, White, etc.
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15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ELECTRICIAN	16b. Kind of Business/Industry ELECTRIC CONTRACTOR
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17. Father's Name (First, Middle, Last) MICHAEL W. R. DUFFY	18. Mother's Name (First, Middle, Maiden Surname) NANCY BOWEN
--	--

19a. Informant's Name/Relationship (Type, Print) CRYSTAL BOWEN, SISTER	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5815 MERIDALE RD. CATONSVILLE, MD. 21228
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20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify: W. ARUNDEL CREMATORIUM	20b. Place of Disposition (Name of cemetery, crematory or other place) Date 3-11-12	20c. Location - City or Town, State ODENTON, MD.
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21. Signature of Funeral Service Licensee A. Dehm MO0942	22. Name and Address of Facility DAUGHERTY FUNERAL HOME 260 MOUNTAIN RD. PASADENA, MD. 21122
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Baltimore, MD 21215-0036

permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

23a. Part I. Enter the disease or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	a. Narcotic (Heroin) Intoxication and cocaine use Due to (or as a consequence of):	Approximate Interval Between Onset and Death
--	--	--

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. _____ Due to (or as a consequence of):	
--	--	--

c. _____ Due to (or as a consequence of):	d. _____ Due to (or as a consequence of):	
--	--	--

<input type="checkbox"/> UNPENDED	<input type="checkbox"/> AMENDED 23a, 27, 28a-f, per me, g925 3-29-12 sm	
-----------------------------------	--	--

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
--	---	---

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
--	--

24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
---	--

25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene
---	--

27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input checked="" type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day, Year) fd 3-8-12	28b. Time of Injury fd 12:12 am	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	28d. Describe how injury occurred unknown
--	---	------------------------------------	---	--

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	Found at Friend's House	28f. Location (Street and Number or Rural Route Number, City or Town, State) 1018 Cape Splitt Harbour Riviera Beach, Md.
---	-------------------------	---

29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29c. License number O.C.M.E. QCME	29d. Date signed (Month, Day, Year) March 8, 2012
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30. Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223
--

31. Date filed (Month, Day, Year) MAR 14 2012	32. Registrar's Signature Anna J. Hall
--	---

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

Medical Certification: To Be Completed by Physician/Medical Examiner**State Registrar**

DHMH 17 Rev 1/2001

OCME 2006

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

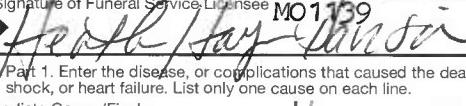
2012 07904

1 - For
State
Registrar

Dyson, Joseph
Baltimore, Maryland 21215-0036

Permit: Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/
Medical
Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death	
JOSEPH A. DYSON		March 11 2012		6:05 AM	
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death	
Greater Baltimore Medical Center		Towson		Baltimore	
5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year)
219-22-1362		1 X M 2 F	84 Yrs.		3/21/1927
9. Birthplace (State or Foreign Country)		10. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
MARYLAND					
10a. State		10b. County		10c. City, Town or Location	
MD		BALTIMORE		GLENDALE	
10e. Street and Number		10f. Zip Code		10g. Citizen of What Country?	
6813 QUEENSFERRY ROAD		21239		USA	
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1945-1946		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				14. Race - American Indian, Black, White, etc. Specify: WHITE	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH GRADE		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) PRINTER		16b. Kind of Business/Industry WAVERLY PRESS	
17. Father's Name (First, Middle, Last) EARL DYSON		18. Mother's Name (First, Middle, Maiden Surname) ELIZABETH LAWRENCE			
19a. Informant's Name/Relationship (Type, Print) PATRICIA KERR/NIECE		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1338 AGORA PLACE BEL AIR, MD 21014			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) DULANEY VALLEY MEM. GARDENS		Date 3/17/2012	20c. Location - City or Town, State COCKEYSVILLE, MD
21. Signature of Funeral Service Licensee MO1139 		22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286			
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death			
a. Due to (or as a consequence of): Hypersensitivity Pneumonitis from Chemotherapy					
b. Due to (or as a consequence of): Pancreatic Cancer		unknown			
c. Due to (or as a consequence of):					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		23f. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier 		29c. License number D0060248		29d. Date signed (Month, Day, Year) March 11, 2012	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JC Greenawalt MD 6701 North Charles Street Baltimore, MD 21204					
31. Date filed (Month, Day, Year) MAR 14 2012		32. Registrar's Signature 			

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

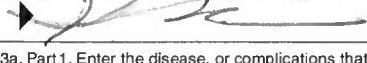
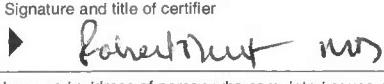
Certificate of Death

Reg. No.

2012

07905

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) SAMUEL JOHN DiBLASI, SR.				2. Date of Death Month March Day 13 , Year 2012	3. Time of Death 12:45 A M	
	4a. Facility Name (If not institution, give street and number) Genesis Healthcare		4b. City, Town, or Location of Death Severna Park		4c. County of Death Anne Arundel		
Funeral Director	5. Social Security Number 217-18-3179		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min.	8. Date of Birth (Month, Day, Year) Jan. 1, 1924	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent		10a. State Maryland 10b. County N/A		10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
To Be Completed by Funeral Director	10e. Street and Number 600 Light Street, Apt. 317			10f. Zip Code 21230		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 0		16b. Kind of Business/Industry Locke Insulator		
	17. Father's Name (First, Middle, Last) Francisco DiBlasi				18. Mother's Name (First, Middle, Maiden Surname) Concetta Mary Rotundo		
	19a. Informant's Name/Relationship (Type. Print) Mrs. Audrey DiBlasi (Wife)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 600 Light St., Apt. 317, Baltimore, Maryland 21230		Date	20c. Location - City or Town, State Baltimore, Maryland	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Most Holy Redeemer Cemetery		20b. Place of Disposition (Name of cemetery, crematory or other place) Most Holy Redeemer Cemetery		Date 3/16/2012	20c. Location - City or Town, State Baltimore, Maryland	
	21. Signature of Funeral Service License  MO0175		22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 130 East Fort Avenue, Baltimore, Maryland 21230				
Physician /Medical Examiner	<p>23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.</p> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. Congestive Heart Failure Due to (or as a consequence of):</p> <p>b. Hypertensive Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____ Due to (or as a consequence of):</p> <p>Approximate Interval Between Onset and Death 1yr.</p>						
Medical Certification: To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year		
	<p>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</p> <p>Acute Renal Failure</p> <p>23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown</p>						
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> D.O.A Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) 4				
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
	5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) At home		28f. Location (Street and Number or Rural Route Number, City or Town, State) 901 E. Fort Ave. Baltimore, MD 21230		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number 13394660		29d. Date signed (Month, Day, Year) March 13, 2012		
	29b. Signature and title of certifier  Robert Rotundo		29c. License number 13394660		29d. Date signed (Month, Day, Year) March 13, 2012		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert Rotundo 901 E. Fort Ave. Baltimore, MD 21230						
State Registrar	31. Date filed (Month, Day, Year) MAR 14 2012		32. Registrar's Signature  Jennifer A. Parker				

Division of Vital Records, P.O. Box 68700

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Patient Known as Dorsey Thomas
Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend #19a Per FH G925 3/14/2012 JH

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07906

1- For State Registrar

**Physician/
Medical
Examiner**

**Funeral
Director**

To Be Completed by Funeral Director

**Physician/
Medical
Examiner**

Medical Certificate: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		THOMAS DORSEY		2. Date of Death		Month March Day 11 Year 2012		3. Time of Death 8:50 ^{AM}	
4a. Facility Name (if not institution, give street and number)		SINAI HOSPITAL OF BALTIMORE		4b. City, Town, or Location of Death		BALTIMORE CITY		4c. County of Death MD	
5. Social Security Number 220-20-4869		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (in yrs. last birthday) 82 Yrs.		If Under 1 Year Months Days Hours Min.		8. Date of Birth (Month, Day, Year) 09-14-1929	
Usual Residence of Decedent								9. Birthplace (State or Foreign Country) MD	
10a. State MD		10b. County		10c. City, Town or Location BALTIMORE				10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number 2020 featherbed Rd.				10f. Zip Code 21207				10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) STATIONARY ENGINEER				16b. Kind of Business/Industry NASA	
17. Father's Name (First, Middle, Last) CHARLES DORSEY SR.				18. Mother's Name (First, Middle, Maiden Surname) CASSIE STOKES					
19a. Informant's Name/Relationship (Type, Print) TESSIE LINSEY (DAUGHTER) Lindsey				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3117 MORAVIA RD, BALTIMORE MARULAND 21214					
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory				Date 3-13-12	20c. Location - City or Town, State BALTIMORE, MARYALND
21. Signature of Funeral Service Licensee ► James A. Morton				22. Name and Address of Facility 1701 Laurens St. Balto. MD 21217 James A. Morton & Son					
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)				CLOSTRIDIUM DIFFICILE COLITIS				Approximate Interval Between Onset and Death	
a. Due to (or as a consequence of):									
b. Due to (or as a consequence of):									
c. Due to (or as a consequence of):									
d. Due to (or as a consequence of):									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. SEVERE MALNUTRITION CORONARY ARTERY DISEASE								23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> D.O.A. Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				23f. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number D0059107				29d. Date signed (Month, Day, Year) 03-13-2012			
29b. Signature and title of certifier ► M. D									
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KALU UMA 210 BUSINESS CENTER DRIVE, REISTERSTOWN, MD 21136									
31. Date filed (Month, Day, Year) MAR 14 2012		32. Registrar's Signature Janice P. Hayes							

**State
Registrar**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07907

1. For State Registrar**Physician/
Medical Examiner**

1. Decedent's Name (First, Middle, Last)	2. Date of Death	3. Time of Death
Emanuel Dean Sr.	Month Day Year March 6, 2012	0144 hrs

Funeral Director

4a. Facility Name (if not institution, give street and number) 1319 North Luzerne Avenue	4b. City, Town, or Location of Death Baltimore	4c. County of Death N/A	
5. Social Security Number 212-42-9554	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 65 Yrs.	If Under 1 Year Months Days Hours Min. If Under 24Hrs.

To Be Completed by Funeral Director

Usual Residence of Decedent
10a. State
MD 10b. County
N/A 10c. City, Town or Location
Baltimore 10d. Inside City Limits
1 Yes 2 No

10e. Street and Number
1319 N. Luzerne Ave. 10f. Zip Code
21213 10g. Citizen of What Country?
U.S.A.

11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? If Yes, Give Year or Dates: 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: Specify: Black	14. Race - American Indian, Black, White, etc.
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)	16b. Kind of Business/Industry Carpenter	16c. Kind of Business/Industry Windsor Mill Co-op

17. Father's Name (First, Middle, Last) Unk	18. Mother's Name (First, Middle, Maiden Surname) Maude Powell
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19a. Informant's Name/Relationship (Type, Print) Mary Dean (wife)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1319 N. Luzerne Ave., Baltimore, MD 21213
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20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify: on-site Crematory	20b. Place of Disposition (Name of cemetery, crematory or other place) on-site Crematory	Date 03/14/12	20c. Location - City or Town, State Baltimore, MD
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21. Signature of Funeral Service Licensee Derrick N. Williams	22. Name and Address of Facility Joseph H. Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 21217
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23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.	Approximate Interval Between Onset and Death
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<input type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
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23e. Did tobacco use contribute to the cause of death? Lung Cancer, diabetes mellitus	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No

25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA	26. Place of Death (Check only one) Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene
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27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred	
				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated	29b. Signature and title of certifier Zabiullah Ali, M.D.	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) March 6, 2012
--	---	--	---

30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223
--

31. Date filed (Month, Day, Year) NAR 14 2012	32. Registrar's Signature Anna J. Parker
---	--

John Edwards

12-01871

UNK UNK

**Physician/
Medical Examiner**

1- For State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07908

**Funeral
Director**

Usual Residence of Decedent

1. Decedent's Name (First, Middle, Last) <i>John Edwards</i>				2. Date of Death Month Day Year March 5, 2012			3. Time of Death 2224 hrs	
4a. Facility Name (if not institution, give street and number) University Hospital				4b. City, Town, or Location of Death Baltimore			4c. County of Death N/A	
5. Social Security Number <i>216-41-7439</i>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>17</i>	Yrs.	If Under 1 Year Months Days Hours Min.	If Under 24 Hrs. Hours Min.	8. Date of Birth (MM/DD/YYYY) <i>Apr 22, 1994</i>	9. Birthplace (State or Foreign Country) <i>Maryland</i>	

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

10a. State <i>MD</i>	10b. County <i>N/A</i>	10c. City, Town or Location <i>Baltimore city</i>	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number <i>3913 Edmondson Ave</i>		10f. Zip Code <i>21229</i>	10g. Citizen of What Country? <i>USA</i>
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify:	14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i>	College (1-4 or 5+) <i>0</i>	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Student</i>	16b. Kind of Business/Industry <i>Education</i>

17. Father's Name (First, Middle, Last)

John Calvin Edwards II

18. Mother's Name (First, Middle, Maiden Surname)

April Waters

19a. Informant's Name/Relationship (Type, Print)

Rovena Edwards

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3913 Edmondson Ave Baltimore, MD 21229

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other Specify:

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory APR.15.2012 Catonsville, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald G Grayson

22. Name and Address of Facility

*Ronald G Grayson Funeral Service
220 Frederick Pass Baltimore, MD 21229*

Baltimore, MD 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial - transit

**Physician
Medical
Examiner**

To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)		a. Gunshot Wound of Head Due to (or as a consequence of):
		b. _____ Due to (or as a consequence of):
		c. _____ Due to (or as a consequence of):
		d. _____
<input type="checkbox"/> UNPENDED	<input type="checkbox"/> AMENDED	

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown

23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (Specify)
9 Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

25. Was case referred to medical examiner?

1 Yes 2 No

26. Place of Death (Check only one)

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other

27. Manner of Death

1 Natural 5 Pending Investigation
2 Accident 6 Could not be determined
3 Suicide 4 Homicide
(Specify) *Local Street*

28a. Date of Injury (Month, Day, Year)

FOUND: Mar 5, 2012

28b. Time of Injury

FOUND: 2130 hrs

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

Subject shot

28e. Place of Injury - At home, farm, street, factory, office building, etc.

28f. Location (Street and Number or Rural Route Number, City or Town, State)
*near of 3510 West Mulberry Street, Baltimore, MD*29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
(Check only one)2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Ling Li, MD

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

March 6, 2012

30. Name and address of person who completed cause of death (Item 23a)

Ling Li, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

31. Date filed (Month, Day, Year)

MAR 14 2012

32. Registrar's Signature

Leanne B. Parker

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07909

1- For State Registrar**Physician/Medical Examiner**

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death 1520 hrs
Thomas R. Edwardsen	February 22, 2012	

4a. Facility Name (if not institution, give street and number) 413 Elm Avenue	4b. City, Town, or Location of Death Glen Burnie	4c. County of Death Anne Arundel
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Funeral Director

5. Social Security Number 216-56-4655	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 61 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (MM/DD/YYYY) 09/09/1950	9. Birthplace (State or Foreign Country) MD
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Usual Residence of Decedent					10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10a. State MD	10b. County Anne Arundel	10c. City, Town or Location Glen Burnie			

10e. Street and Number 413 Elm Avenue	10f. Zip Code 21061	10g. Citizen of What Country? USA
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11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify:	14. Race - American Indian, Black, White, etc. White Specify:
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15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) HVAC Repairman	16b. Kind of Business/Industry Refrigeration
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17. Father's Name (First, Middle, Last) Edward Edwardsen	18. Mother's Name (First, Middle, Maiden Surname) Eileen E. Nice
---	---

19a. Informant's Name/Relationship (Type, Print) Louise Edwardsen Sister	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9313 Seabay Court Sparrows Point MD21219
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20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify: Atlantic Crem	20b. Place of Disposition (Name of cemetery, crematory or other place) Date 3/7/2012	20c. Location - City or Town, State Glen Burnie MD
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21. Signature of Funeral Service Licensee Thomas Allen	22. Name and Address of Facility Simplicity Crem & Fun Serv ThomasAllenPA 7090 Ridge Rd Hanover MD
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Baltimore, MD 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Cardiovascular Disease Due to (or as a consequence of):	
b.	
c.	
d.	

<input checked="" type="checkbox"/> UNPENDED	<input type="checkbox"/> AMENDED 23a, 27, per me, g927 5-2-12 sm
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IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
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	24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
--	---	--

25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA	26. Place of Death (Check only one) 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene
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27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
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28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
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29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29c. License number O.C.M.E. OCME	29d. Date signed (Month, Day, Year) February 23, 2012
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30. Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223
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31. Date filed (Month, Day, Year) MAR 14 2012	32. Registrar's Signature Lorraine J. Pace
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend item 30 per dvr g925 3-14-12 vt

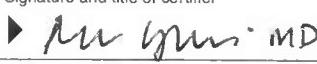
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07910

1 - For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DORIS MAY FARRELL						2. Date of Death Month Day Year March 8, 2012	3. Time of Death 7:00 p M
	4a. Facility Name (If not institution, give street and number) Harbor Hospital			4b. City, Town, or Location of Death Baltimore			4c. County of Death	
Funeral Director	5. Social Security Number 220-20-5493		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) May 6, 1928	9. Birthplace (State or Foreign Country) Maryland
Usual Residence of Decedent		10a. State MD	10b. County	10c. City, Town or Location Baltimore				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number 1445 Riverside Avenue		10f. Zip Code 21230				10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1945		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Glass Production		16b. Kind of Business/Industry Glass Production				
17. Father's Name (First, Middle, Last) Lawrence J. Ruff					18. Mother's Name (First, Middle, Maiden Surname) Mary C. Conway			
19a. Informant's Name/Relationship (Type, Print) William Farrell son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 105 East Randall Street Baltimore, Maryland 21230						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) 1270		20b. Place of Disposition (Name of cemetery, crematory or other place) Crownsville Veterans Cem.		Date 3/13/2012	20c. Location - City or Town, State Crownsville, Maryland			
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility McCully Polyniak Funeral Home, P.A. 130 East Fort Avenue Baltimore, Maryland 21230						
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Ischemic heart disease Approximate Interval Between Onset and Death 10 yrs								
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Diabetes mellitus 40 yrs								
23b. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) End stage renal disease Approximate Interval Between Onset and Death 40 yrs								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Emphysema, chronic obstructive pulmonary disease								
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown								
23f. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 		29c. License number D51807				29d. Date signed (Month, Day, Year) March 9, 2012		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gloria Yim 419 W. Redwood St. Suite 620 Baltimore, Md. 21201								
31. Date filed (Month, Day, Year) MAR 14 2012		32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

5 ✓

Division of Vital Records, P.O. Box 68760,

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Amend Item 29d per dr., g925, 03/14/2012dhb
Registrar

Certificate of Death

Reg. No.

2012 07911

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last)							2. Date of Death			3. Time of Death				
	Amelia B. Ganz							Month March Day 4 Year 2012			9:03 AM				
Funeral Director	4a. Facility Name (if not institution, give street and number)			4b. City, Town, or Location of Death				4c. County of Death							
	St. Agnes Hospital			Baltimore				MD							
To Be Completed by Funeral Director	5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)		If Under 1 Year		If Under 24 Hrs.		8. Date of Birth (Month, Day, Year)		9. Birthplace (State or Foreign Country)			
	220-05-3569		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	90 Yrs.		Months	Days	Hours	Min.	12/19/1921		MD			
10a. State	10b. County		10c. City, Town or Location								10d. Inside City Limits				
MD	Baltimore		Catonsville								1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
10e. Street and Number				10f. Zip Code				10g. Citizen of What Country?							
1009 Elm Ridge Avenue				21229				USA							
11. Marital Status			12. Was Decedent Ever in U.S. Armed Forces?			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			14. Race - American Indian, Black, White, etc.						
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.			1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			Specify: White						
15. Decedent's Education (Specify only highest grade completed)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)				16b. Kind of Business/Industry							
Elementary/Secondary (0-12) 11				College (1-4 or 5+) Administrative Asst.				Clerical							
17. Father's Name (First, Middle, Last)						18. Mother's Name (First, Middle, Maiden Surname)									
Joseph Savoner						Katherine Riesz									
19a. Informant's Name/Relationship (Type, Print)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)											
William J. Ganz Jr. (Son)				3436 Nanmark Ct. Ellicott City, Md. 21042.											
20a. Method of Disposition				20b. Place of Disposition (Name of cemetery, crematory or other place)				Date		20c. Location - City or Town, State					
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				Crestlawn Mem Gardens				3/9/2012		Marriottsville, MD					
21. Signature of Funeral Service Licensee				22. Name and Address of Facility											
<i>Robert L. Ganz</i>				Haight Funeral Home & Chapel PO Box 195, Sykesville, MD 21784											
Physician/ Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death				
	<p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <u>Pneumonia</u> Due to (or as a consequence of):</p> <p>b. <u>A fib with RVR</u> Due to (or as a consequence of):</p> <p>c. <u>Severe Aortic stenosis</u> Due to (or as a consequence of):</p> <p>d. _____</p>										<p>2 days</p> <p>2 days</p> <p>5 days</p>				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown								23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
										24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one)													
		Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DCA				Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death		28a. Date of injury (Month, Day, Year)		28b. Time of injury		28c. Injury at work?		28d. Describe how injury occurred							
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Pending Investigation 3 <input type="checkbox"/> Accident 4 <input type="checkbox"/> Suicide 5 <input type="checkbox"/> Could not be determined		M		M		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No									
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one)		29b. Signature and title of certifier										29c. License number			
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		<i>M. A.</i>										29d. Date signed (Month, Day, Year)			
		<i>M. A.</i>										<i>P25485</i>		<i>March 4, 2012</i>	
														<i>Feb 4th 2012</i>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)															
<i>Marta Shercher, 900 S. Caton Avenue, Baltimore, MD 21229</i>															
31. Date filed (Month, Day, Year)		32. Registrar's Signature													
<i>MAR 14 2012</i>		<i>Susan J. Parker</i>													

Ganz, Amelia
Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07912

1- For
State
Registrar

Physician/
Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/
Medical
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Physician or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. Decedent's Name (First, Middle, Last) John W. Hodges		2. Date of Death Month March		3. Time of Death Year 6 2012 7:20 PM	
4a. Facility Name (if not institution, give street and number) Southern Maryland Hospital		4b. City, Town, or Location of Death Clinton		4c. County of Death Prince George's	
5. Social Security Number 258-70-6627		6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 67 Yrs.	If Under 1 Year Months 	If Under 24 Hrs. Days
8. Date of Birth (Month, Day, Year) Feb 13 1945		9. Birthplace (State or Foreign Country) GA		10d. Inside City Limits 1 X Yes 2 No	
10a. State MD		10b. County Prince George's		10c. City, Town or Location Temple Hills	
10e. Street and Number 5311 Ludlow Drive		10f. Zip Code 20748		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates. Army		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: 	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 2+		16b. Kind of Business/Industry Postal Distributor	
17. Father's Name (First, Middle, Last) Mora Hodges		18. Mother's Name (First, Middle, Maiden Surname) Maudie Harris			
19a. Informant's Name/Relationship (Type, Print) Lolita Hodges/ Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5311 Ludlow Drive, Temple Hills, Maryland 20748			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Resurrection Cemetery		Date 03/16/2012	20c. Location - City or Town, State Clinton, Maryland
21. Signature of Funeral Service Licensee Bryan Hunter		22. Name and Address of Facility J.B. Jenkins Funeral Home 7474 Landover Road, Landover, Maryland 20785			
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death	
a. Massive Myocardial Infarcting Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
24. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number DL64055		29d. Date signed (Month, Day, Year) 03/07/12	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eric McDonald 7503 Sunnyside Rd. Clinton, MD 20735		31. Date filed (Month, Day, Year) MAR 14 2012		32. Registrar's Signature James M. Parker	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07913

1 - For
State
RegistrarPhysician/
Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician/ Medical Examiner		Decedent's Name (First, Middle, Last) Mark Timothy Halischak, Sr.						2. Date of Death Month March	Day 12	Year 2012	3. Time of Death 2:15 A M
Funeral Director		4a. Facility Name (if not institution, give street and number) 29 Glenwood Road Apt B			4b. City, Town, or Location of Death Essex			4c. County of Death Baltimore			
		5. Social Security Number 268-50-0531	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 54 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	Hours	Min.	8. Date of Birth (Month, Day, Year) 06/18/1957	9. Birthplace (State or Foreign Country) Ohio	
		Usual Residence of Decedent 10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Essex			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		10e. Street and Number 29 Glenwood Road Apt B			10f. Zip Code 21221			10g. Citizen of What Country? U.S.A.			
		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates. 2		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. Specify: White			
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Janitor			16b. Kind of Business/Industry Housing				
		17. Father's Name (First, Middle, Last) George Halischak			18. Mother's Name (First, Middle, Maiden Surname) Anna Mae Labas						
		19a. Informant's Name/Relationship (Type, Print) Annette S. Cancilla Halischak		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29 Glenwood Road Apt B Essex, Maryland 21221							
		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) St Andrew Cemetery		20b. Place of Disposition (Name of cemetery, crematory or other place) St Andrew Cemetery			Date 03/17/2012	20c. Location - City or Town, State Mingo Junction, Ohio			
		21. Signature of Funeral Service Licensee ► Michael P. Marzullo		22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 6009 Harford Road Baltimore, Maryland 21221							
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)			Metastatic Pancreatic Cancer			Approximate Interval Between Onset and Death 2 months			
		<p>a. Due to (or as a consequence of):</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>									
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year				
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
								<p>24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>			
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA			Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred				
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
		29a. Certifier <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
		29b. Signature and title of certifier ► M.D.		29c. License number 045390			29d. Date signed (Month, Day, Year) March 12th 2012				
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thyomin (M.D.) 9114 Philadelphia Road #208, Baltimore MD 21237									
		31. Date filled (Month, Day, Year) MAR 14 2012		32. Registrar's Signature Leanne J. Farrel							

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

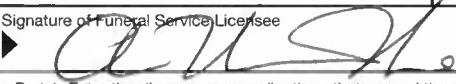
Certificate of Death

Reg. No. 2012 07914

1 - For State Registrar

**Physician/
Medical
Examiner**

1. Decedent's Name (First, Middle, Last) James Davie Hendry							2. Date of Death Month March Day 9 , Year 2012	3. Time of Death 9:45 P M	
4a. Facility Name (if not institution, give street and number) Charlestown Care Center				4b. City, Town, or Location of Death Catonsville			4c. County of Death Baltimore		
5. Social Security Number 039-14-1406		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) May 8, 1928	9. Birthplace (State or Foreign Country) Rhode Island		
Usual Residence of Decedent									
10a. State MD	10b. County Baltimore	10c. City, Town or Location Catonsville						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 717 Maiden Choice Lane ST610				10f. Zip Code 21228			10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Commander			16b. Kind of Business Industry U.S. Navy				
17. Father's Name (First, Middle, Last) William Davie Hendry					18. Mother's Name (First, Middle, Maiden Surname) Helena Salmon				

19a. Informant's Name/Relationship (Type, Print) Juanita Hendry Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 717 Maiden Choice Lane-ST610; Catonsville, MD 21228			Date	20c. Location - City or Town, State Glen Burnie, MD
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Atlantic Crematory			3-13-2012	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228				

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Metastatic prostate cancer			Approximate Interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. Due to (or as a consequence of):			
{		b. Due to (or as a consequence of):			
{		c. Due to (or as a consequence of):			
{		d. Due to (or as a consequence of):			

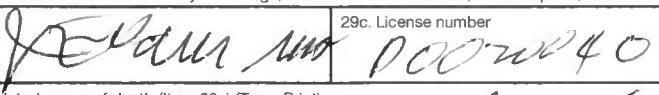
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No

25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
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27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work? M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number 000-000-40			29d. Date signed (Month, Day, Year) 3/10/12
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29b. Signature and title of certifier 		29c. License number 000-000-40			29d. Date signed (Month, Day, Year) 3/10/12
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J Evans no 717 Maiden Choice Lane, Catonsville					

31. Date filed (Month, Day, Year) MAR 14 2012		32. Registrar's Signature Janice S. Parks			
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Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit once.

**State
Registrar**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM 79 per FH, G925, 3/21/2012, WS

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07915

1- For
State
RegistrarPhysician/
Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/
Medical
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

1. Decedent's Name (First, Middle, Last) URSULA V. HEIN		2. Date of Death Month Day Year MARCH 8, 2012		3. Time of Death 10:53 PM
4a. Facility Name (if not institution, give street and number) 3827 WINCHESTER LN.		4b. City, Town, or Location of Death BOWIE		4c. County of Death PRINCE GEORGES
5. Social Security Number 414.52.3769		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months Days Hours Min. If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) AUG 30, 1925
Usual Residence of Decedent MD ANNE ARUNDEL		10c. City, Town or Location GLEN BURNIE		9. Birthplace (State or Foreign Country) Germany
10a. State MD		10b. County ANNE ARUNDEL		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number 107 S. JEROME PKWY.		10f. Zip Code 21060		10g. Citizen of What Country? USA
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates XX		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: XX
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 3 HOMEMAKER		16b. Kind of Business/Industry OWN HOME
17. Father's Name (First, Middle, Last) JACOB C. HALSY		18. Mother's Name (First, Middle, Maiden Surname) IRENE JAHN		
19a. Informant's Name/Relationship (Type, Print) CALVIN HEIN HUSBAND		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 107 S. JEROME PKWY. GLEN BURNIE, MD 21060		
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) BAYVIEW CREMATORIAL INC		20b. Place of Disposition (Name of cemetery, crematory or other place) BAYVIEW CREMATORIAL INC		Date 3.10.2012
21. Signature of Funeral Service Licensee K. GREGORY FINK		22. Name and Address of Facility FTNK FUNERAL HOME, P.A. 426 CRAIN HWY SW GLEN BURNIE, MD 21061		20c. Location - City or Town, State BALTIMORE, MD
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death
<p>a. Due to (or as a consequence of): <i>Cerebrovascular accident</i></p> <p>b. Due to (or as a consequence of): <i>Heart failure</i></p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> <i>Daughter's Home</i>		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred
29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number 038958		29d. Date signed (Month, Day, Year) 3/9/12
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Geet Singh, MD 208 Crain Hwy Sw Glen Burnie MD 21061		31. Date filed (Month, Day, Year) MAR 14 2012		32. Registrar's Signature <i>Geet Singh</i>

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
 amend item 18 per fh g925 3-21-12 vt

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07916

1 - For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Harry Franklin Horney, IV							2. Date of Death Month: March Day: 12 Year: 2012	3. Time of Death 12:02 A M
	4a. Facility Name (if not institution, give street and number) 11817 Cedar Lane			4b. City, Town, or Location of Death Kingsville			4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 219-78-9901	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 52 Yrs.	If Under 1 Year Months 0	If Under 24 Hrs. Hours 0	Min. 0	8. Date of Birth (Month/Day/Year) 06/16/1959	9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent 10a. State MD		10b. County Baltimore		10c. City, Town or Location Kingsville				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
To Be Completed by Funeral Director	10e. Street and Number 11817 Cedar Lane			10f. Zip Code 21087			10g. Citizen of What Country? USA		
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Maintenance			16b. Kind of Business Industry Residential Maintenance		
17. Father's Name (First, Middle, Last) Ronald Leroy Horney, Sr				18. Mother's Name (First, Middle, Maiden Surname) June Lamarche LaMarche					
19a. Informant's Name/Relationship (Type, Print) Ronald Leroy Horney, Jr. / Brother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 321 North 1500 West Tremonton, UT 84337					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory			Date 3/13/2012	20c. Location - City or Town, State Beltsville, MD	
21. Signature of Funeral Service Licensee Dorota Marshall				22. Name and Address of Facility Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203					
Physician/ Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)								Approximate Interval Between Onset and Death
	<p>a. Pancreatic Cancer Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>								
23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown						23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier 		29c. License number D0071287				29d. Date signed (Month, Day, Year) 3/12/12			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Philip Shaheen, 6101 N. Charles St. #4105, Baltimore, MD 21204									
31. Date filed (Month, Day, Year) MAR 14 2012		32. Registrar's Signature 							

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

State
Registrar

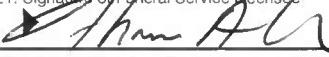
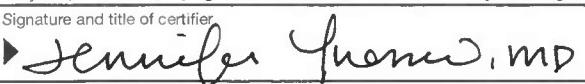
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State of Maryland / Department of Health and Mental Hygiene

1- For State Amend Item 25 per verb., g925, 03/14/2012 dhp
Registrar Certificate of Death

Reg. No.

2012 07917

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Robert Jones							2. Date of Death Month Day Year February 27, 2012			3. Time of Death 2:04 PM	
	4a. Facility Name (if not institution, give street and number) Harbor Hospital							4b. City, Town, or Location of Death Baltimore			4c. County of Death MD	
Funeral Director	5. Social Security Number UNIK		6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 55 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month Day Year) 11/26/1956	9. Birthplace (State or Foreign Country) MD				
	Usual Residence of Decedent		10a. State MD		10b. County Anne Arundel	10c. City, Town or Location Ferndale		10d. Inside City Limits 1 Yes 2 No				
To Be Completed by Funeral Director	10e. Street and Number 703 Wellham Ave				10f. Zip Code 21061			10g. Citizen of What Country? USA				
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Truck Driver			16b. Kind of Business/Industry Trucking				
	17. Father's Name (First, Middle, Last) Stephen Jones				18. Mother's Name (First, Middle, Maiden Surname) Betty Grempler							
	19a. Informant's Name/Relationship (Type, Print) Stephen Jones III Nephew				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1301 Hazel Nut Court Annapolis MD 21409							
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) Atlantic Crem				20b. Place of Disposition (Name of cemetery, crematory or other place) Atlantic Crem			Date 02/29/12	20c. Location - City or Town, State Glen Burnie MD			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Simplicity Crem & Fun Serv Thomas Allen PA 7090 Ridge Rd Hanover MD							
Physician/ Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)				23b. Part 2. Enter the disease, or complications that contributed to the death but did not cause it. List only one cause on each line. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			23c. Approximate Interval Between Onset and Death				
	<p>a. <u>Hepatic carcinoma, stage 4</u> Due to (or as a consequence of):</p> <p>b. <u>End stage liver disease</u> Due to (or as a consequence of):</p> <p>c. <u>Alcoholism</u> Due to (or as a consequence of):</p> <p>d. <u>Hepatitis C</u> Due to (or as a consequence of):</p>											
Physician/ Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year							
Medical Certificate: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Pending Investigation 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred					
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number RES001		29d. Date signed (Month, Day, Year) February 27, 2012							
	29b. Signature and title of certifier 											
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jennifer Thomas 3001 South Hanover Street, Baltimore, MD 21225											
State Registrar	31. Date filed (Month, Day, Year) MAR 14 2012		32. Registrar's Signature 									

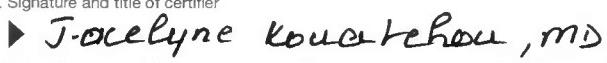
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07918

1 - For
State
Registrar

Physician/ Medical Examiner Funeral Director To Be Completed by Funeral Director	<p>1. Decedent's Name (First, Middle, Last) JOHN JENKINS</p> <p>2. Date of Death Month MARCH Day 6 Year 2012</p> <p>3. Time of Death 2:25 P M</p> <p>4a. Facility Name (if not institution, give street and number) 4503 RUNNING DEER WAY</p> <p>4b. City, Town, or Location of Death BOWIE</p> <p>4c. County of Death PRINCE GEORGE'S</p> <p>5. Social Security Number 577-46-2530</p> <p>6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F</p> <p>7. Age (In yrs. last birthday) 76 Yrs.</p> <p>If Under 1 Year Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min.</p> <p>8. Date of Birth (Month, Day, Year) OCT. 4 1935</p> <p>9. Birthplace (State or Foreign Country) WASHINGTON, DC</p> <p>10a. State MD</p> <p>10b. County PRINCE GEORGE'S</p> <p>10c. City, Town or Location BOWIE</p> <p>10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>10e. Street and Number 4503 RUNNING DEER WAY</p> <p>10f. Zip Code 20720</p> <p>10g. Citizen of What Country? USA</p> <p>11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced</p> <p>12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No USAF If Yes, Give Year or Dates.</p> <p>13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:</p> <p>14. Race - American Indian, Black, White, etc. BLACK Specify:</p> <p>15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2+ College (1-4 or 5+)</p> <p>16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) COMMUNICATION SPECIALIST</p> <p>16b. Kind of Business Industry GOVERNMENT</p> <p>17. Father's Name (First, Middle, Last) JESSE JAMES JENKINS</p> <p>18. Mother's Name (First, Middle, Maiden Surname) FANNIE MAE WOODS</p> <p>19a. Informant's Name/Relationship (Type, Print) JANIE L. JENKINS/WIFE</p> <p>19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4503 RUNNING DEER WAY BOWIE, MARYLAND 20720</p> <p>20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)</p> <p>20b. Place of Disposition (Name of cemetery, crematory or other place) ARLINGTON CEMETERY</p> <p>Date 3/24/2012</p> <p>20c. Location - City or Town, State ARLINGTON, VIRGINIA</p> <p>21. Signature of Funeral Service Licensee </p> <p>22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785</p>					
Physician/ Medical Examiner Medical Certificate: To Be Completed by Physician/Medical Examiner	<p>23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.</p> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</p> <p>23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown</p> <p>23d. Date of delivery Month Day Year</p> <p>23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown</p> <p>24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</p> <p>24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</p> <p>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</p> <p>26. Place of Death (Check only one) 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</p> <p>28a. Date of injury (Month, Day, Year) 28b. Time of injury M 28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>28d. Describe how injury occurred</p> <p>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)</p> <p>28f. Location (Street and Number or Rural Route Number, City or Town, State)</p> <p>29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</p> <p>29b. Signature and title of certifier </p> <p>29c. License number D63748</p> <p>29d. Date signed (Month, Day, Year) MARCH 8, 2012</p> <p>30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOCELYNE KOUATCHOU M.D. 201 EAST UNIVERSITY PARKWAY BALTIMORE, MARYLAND 21218</p> <p>31. Date filed (Month, Day, Year) MAR 14 2012</p> <p>32. Registrar's Signature </p>					

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

**State
Registrar**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07919

1- For State Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Javon D. Johnson					2. Date of Death Month Day Year March 8, 2012	3. Time of Death 0002 hrs
Funeral Director	4a. Facility Name (if not institution, give street and number) University Hospital Shock Trauma			4b. City, Town, or Location of Death Baltimore			4c. County of Death NA
5. Social Security Number 214-31-8653		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 21 Yrs.	If Under 1 Year Months Days Hours Min. 	If Under 24 Hrs. 	8. Date of Birth (MM/DD/YYYY) 12-12-90	9. Birthplace (State or Foreign Country) MD
10a. State MD		10b. County Baltimore	10c. City, Town or Location Gwynn Oak				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
10e. Street and Number 7120 Marston Road				10f. Zip Code 21207			10g. Citizen of What Country? USA
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify:			14. Race - American Indian, Black, White, etc. African American
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Grade 2yrs.				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DD NDT use retired) Student			16b. Kind of Business/Industry Student
17. Father's Name (First, Middle, Last) Jack Johnson				18. Mother's Name (First, Middle, Maiden Surname) Markeda Burrell			
19a. Informant's Name/Relationship (Type, Print) Myronetta Smith-Cousin				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7120 Marston Road Gwynn Oak, Maryland			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify: Mt. Zion Cem.				20b. Place of Disposition (Name of cemetery, crematory or other place)		Date 03-17-12	20c. Location - City or Town, State Lansdowne, MD
21. Signature of Funeral Service Licensee Amelia Hampton				22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, MD 21217			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
a. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): _____							
b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last Due to (or as a consequence of): _____							
c. Due to (or as a consequence of): _____							
d. _____							
<input type="checkbox"/> UNPENDED		<input type="checkbox"/> AMENDED					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown _____							
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No							
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Dutypatient 3 <input type="checkbox"/> DDA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other:							
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide		28a. Date of Injury (Month Day Year) Mar 7, 2012		28b. Time of Injury 2331 hrs	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	28d. Describe how injury occurred Subject shot	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Local Street		28f. Location (Street and Number or Rural Route Number, City or Town, State) 2200 W. North Ave, Baltimore, MD			
29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier Amelia Brassell, MD Assistant Medical Examiner				29c. License number O.C.M.E.			29d. Date signed (Month, Day, Year) March 8, 2012
30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223							
31. Date filed (Month, Day, Year) MAR 14 2012 32. Registrar's Signature Leanne A. Parker							

Baltimore, MD 21215-0036

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

State Registrar

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07920

1- For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Rosemary Juricak							2. Date of Death Month March	Day 7	Year 2012	3. Time of Death 10:53 A M
	4a. Facility Name (if not institution, give street and number) St. Catherine's Nursing Center				4b. City, Town, or Location of Death Emmitsburg			4c. County of Death Frederick			
Funeral Director	5. Social Security Number 382-07-3394		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 93 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) 05/19/1918	9. Birthplace (State or Foreign Country) Michigan			
	10a. State MD		10b. County Frederick		10c. City, Town or Location Emmitsburg			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
To Be Completed by Funeral Director	10e. Street and Number 331 South Seton Avenue				10f. Zip Code 21727			10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business Industry Own Home			
	17. Father's Name (First, Middle, Last) Raymond Magnan				18. Mother's Name (First, Middle, Maiden Surname) Mary Sprader						
	19a. Informant's Name/Relationship (Type, Print) David M. Dancer / Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14105 Marian Drive, Rockville, MD 20850						
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Dorota Marshall				20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory			Date 3/11/2012	20c. Location - City or Town, State Beltsville, MD		
	21. Signature of Funeral Service Licensee Dorota Marshall				22. Name and Address of Facility Maryland Cremation Services, POBox 1413 Baltimore, MD 21203						
Physician/ Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Advanced Dementia									Approximate Interval Between Onset and Death Years	
	<p>a. Due to (or as a consequence of): Advanced Dementia</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. _____</p>										
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
Medical Certificate: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic renal failure gastric retention									23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
										24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOD Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide				28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
					28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29c. License number 00018705			29d. Date signed (Month, Day, Year) 3/7/12			
	29b. Signature and title of certifier Alan Carroll										
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alan Carroll 310 S. Seton Ave Emmitsburg MD 21727										
	31. Date filled (Month, Day, Year) MAR 14 2012				32. Registrar's Signature Leanne J. Gales						

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07921

1 - For
State
Registrar

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) Emily Fraser Kittle						2. Date of Death Month March Day 11 Year 2012	3. Time of Death 3:23 p M		
Funeral Director		4a. Facility Name (if not institution, give street and number) Hospice of Queen Anne's						4b. City, Town, or Location of Death Centreville	4c. County of Death Queen Anne's		
To Be Completed by Funeral Director		5. Social Security Number 219-64-7686	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 56 Yrs.	If Under 1 Year Months 	If Under 24 Hrs. Days 	8. Date of Birth (Month, Day, Year) 11/25/1955	9. Birthplace (State or Foreign Country) Washington D.C.			
To Be Completed by Physician/Medical Examiner		10a. State Maryland	10b. County Caroline	10c. City, Town or Location Preston			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
Medical Certificate To Be Completed by Physician/Medical Examiner		10e. Street and Number 20992 Tanyard Estates Drive			10f. Zip Code 21655			10g. Citizen of What Country? U.S.A.			
To Be Completed by Physician/Medical Examiner		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
To Be Completed by Physician/Medical Examiner		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 2 Medical Assistant			16b. Kind of Business/Industry Shore Health System				
To Be Completed by Physician/Medical Examiner		17. Father's Name (First, Middle, Last) Forna Richard Weinrich				18. Mother's Name (First, Middle, Maiden Surname) Edith Elizabeth Fraser					
To Be Completed by Physician/Medical Examiner		19a. Informant's Name/Relationship (Type, Print) Barbara Wilhelm			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 126 West Virginia Avenue Severn, Maryland 21144						
To Be Completed by Physician/Medical Examiner		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Ardent Cremation			Date 3-14-12	20c. Location - City or Town, State Hanover, Maryland		
To Be Completed by Physician/Medical Examiner		21. Signature of Funeral Service Licensee Michael P Marzullo			22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 6009 Harford Road Baltimore, Maryland 21214						
To Be Completed by Physician/Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cholangio carcinoma									Approximate Interval Between Onset and Death 2 years
To Be Completed by Physician/Medical Examiner		23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown									
To Be Completed by Physician/Medical Examiner		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown									23d. Date of delivery Month Day Year
To Be Completed by Physician/Medical Examiner		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
To Be Completed by Physician/Medical Examiner		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
To Be Completed by Physician/Medical Examiner		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA			Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Hospice House			
To Be Completed by Physician/Medical Examiner		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide			28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred			
To Be Completed by Physician/Medical Examiner		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)						
To Be Completed by Physician/Medical Examiner		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29c. License number D47232			29d. Date signed (Month, Day, Year) 3/13/2012			
To Be Completed by Physician/Medical Examiner		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mary S. De Shields, MD 509 Oldewold Ave Ste 1 Easton, MD 21601									
To Be Completed by Physician/Medical Examiner		31. Date filed (Month, Day, Year) MAR 14 2012			32. Registrar's Signature Susan S. Parker						

Division of Vital Records, P.O. Box 68760

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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State
Registrar

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07922

For
State
Registrar

Physician/
Medical
Examiner

Funeral
Director

Baltimore, Maryland 21215-0036
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) Yunn-Jenn Kao			2. Date of Death Month Mar Day 11 Year 2012			3. Time of Death 1:40 A M		
4a. Facility Name (if not institution, give street and number) Lorien Nursing Home			4b. City, Town, or Location of Death Columbia			4c. County of Death Howard		
5. Social Security Number 213-94-2335	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 92 Yrs.	If Under 1 Year Months <input type="checkbox"/>	If Under 24 Hrs. Days <input type="checkbox"/>	Hours <input type="checkbox"/>	Min. <input type="checkbox"/>	8. Date of Birth (Month, Day, Year) Aug 5, 1919	9. Birthplace (State or Foreign Country) China
Usual Residence of Decedent MD		10b. County Howard		10c. City, Town or Location Columbia				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number 6334 Cedar Lane			10f. Zip Code 21044			10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Chinese	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home		
17. Father's Name (First, Middle, Last) Fang Kuo			18. Mother's Name (First, Middle, Maiden Surname) unknown					
19a. Informant's Name/Relationship (Type, Print) Dr. Luke Kao son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11742 Spring Haven Ct. Ellicott City, MD 21042					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) UNK			20b. Place of Disposition (Name of cemetery, crematory or other place) Columbia Memorial Park			Date Mar 15, 2012	20c. Location - City or Town, State Clarksville, Maryland	
21. Signature of Funeral Service Licensee Unreadable signature			22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043					

Medical Certificate: To Be Completed by Physician/Medical Examiner

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		ASPIRATION PNEUMONIA			Approximate Interval Between Onset and Death days
{ a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DEMENTIA		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Only one		29c. License number 00053150			29d. Date signed (Month, Day, Year) MARCH 12 2012
29b. Signature and title of certifier Spoonie MD					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shakun male jyoti 9650 Seneca Rd Suite 110 MD Columbia 21045					
31. Date filed (Month, Day, Year) MAR 14 2012		32. Registrar's Signature Leanne S. Gates			

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
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Baltimore, Maryland 21215-0036

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

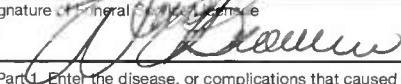
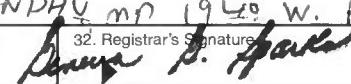
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07923

1 - For
State
Register

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) BUSTER LAWRENCE JR.				2. Date of Death Month Day Year March 7, 2012		3. Time of Death 1914 M					
Funeral Director		4a. Facility Name (If not institution, give street and number) Maryland General Hospital				4b. City, Town, or Location of Death Baltimore City		4c. County of Death N/A					
To Be Completed by Funeral Director		5. Social Security Number 422-40-3972		6. Sex 1 X M 2 □ F		7. Age (In yrs. last birthday) 77 Yrs.		8. Date of Birth (Month, Day, Year) JUL. 7 1934					
						If Under 1 Year Months Days Hours Min.		9. Birthplace (State or Foreign Country) ALABAMA					
		10a. State MARYLAND		10b. County N/A		10c. City, Town or Location BALTIMORE				10d. Inside City Limits XX Yes 2 □ No			
		10e. Street and Number 2801 PRESSTMAN STREET				10f. Zip Code 21216				10g. Citizen of What Country? U.S.A.			
		11. Marital Status 1 □ Never Married 2 XX Married 3 □ Widowed 4 □ Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 XX No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No) 1 □ Yes 2 XX No Specify:			14. Race - American Indian, Black, White, etc. Specify: BLACK		
		15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) 10th grade				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CAB DRIVER				16b. Kind of Business Industry TRANSPORTATION			
		17. Father's Name (First, Middle, Last) BUSTER LAWRENCE SR.				18. Mother's Name (First, Middle, Maiden Surname) CALLIE MURPHY							
		19a. Informant's Name/Relationship (Type, Print) Dorothy Lawrence/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2801 Presstman St., Baltimore, Md., 21216							
		20a. Method of Disposition XX Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) ARUBUTUS MEMORIAL			Date 03-16-2012		20c. Location - City or Town, State BALTIMORE, MARYLAND			
		21. Signature of Physician/Medical Examiner 				22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 2106 W NORTH AVENUE							
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)				coronary artery disease				Approximate Interval Between Onset and Death			
		<p>a. Due to (or as a consequence of):  coronary artery disease</p> <p>b. Due to (or as a consequence of): </p> <p>c. Due to (or as a consequence of): </p> <p>d. Due to (or as a consequence of): </p>											
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		23c. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown				23d. Date of delivery Month Day Year					
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension, stroke				23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 □ Probably 4 <input checked="" type="checkbox"/> Unknown							
										24a. Was an autopsy performed? 1 □ Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 <input checked="" type="checkbox"/> No	
		25. Was case referred to medical examiner? 1 □ Yes 2 □ No		Hospital: 1 □ Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 □ DDA Other: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)				26. Place of Death (Check only one)					
		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at work? 1 □ Yes 2 □ No		28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)					
		29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
		29b. Signature and title of certifier  PHYSICIAN		29c. License number D 57543				29d. Date signed (Month, Day, Year) 3-9-12					
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PREETINDER SANDHU 1940 W. BALTIMORE ST BALTIMORE, MD 21223											
		31. Date filed (Month, Day, Year) MAR 14 2012		32. Registrar's Signature 									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM #31 per DMR, G925, 3/14/2012, WS

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07924

1 - For
State
Registrar**Physician/
Medical
Examiner**

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) Dorothy Marie Lantz				2. Date of Death Month 03 Day 06 Year 2012				3. Time of Death 10:45 a.m.
4a. Facility Name (if not institution, give street and number) Anne Arundel Medical Center				4b. City, Town, or Location of Death Annapolis				4c. County of Death Anne Arundel
5. Social Security Number 232-46-4156		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) 08/19/1929	9. Birthplace (State or Foreign Country) West Virginia	
10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Annapolis				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number 2310 River Crescent Drive				10f. Zip Code 21401				10g. Citizen of What Country? U.S.A
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) School Teacher				16b. Kind of Business/Industry Education
17. Father's Name (First, Middle, Last) Arthur Ernest				18. Mother's Name (First, Middle, Maiden Surname) Isabelle Crangle				
19a. Informant's Name/Relationship (Type, Print) Lynn E. Lantz				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 825 Dixon Avenue Sykesville, Maryland 21784				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Heavner Cemetery			Date 3/10/2012	20c. Location - City or Town, State Buckhannon, WV
21. Signature of Funeral Service Licensee Michael J. Marzullo				22. Name and Address of Facility Marzullo Funeral Chapel P.A. 6009 Harford Road Baltimore, Maryland 21214				

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year		Approximate Interval Between Onset and Death	
CARDIAC FAILURE SEPSIS Leg wounds Hypoalbuminemia									
		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
		23f. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		23g. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		26. Place of Death (Check only one) <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier Savanna P. Prasad MD		29c. License number D 69482		29d. Date signed (Month, Day, Year) 3/6/12					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Savanna Prasad MD 2001 Medical Parkway Annapolis, MD									
31. Date filed (Month, Day, Year) 3/6/12 MAR 14 2012		32. Registrar's Signature Savanna P. Prasad							

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07925

1 - For
State
Registrar

1. Decedent's Name (First, Middle, Last)

Waneta Elizabeth Leake

2. Date of Death

Month

Day

Year

3. Time of Death

7:10 P M

February

26, 2012

Physician/
Medical
Examiner

4c. County of Death

Anne Arundel

Funeral
Director

4b. City, Town, or Location of Death

Severn

5. Social Security Number

486-26-9751

6. Sex

1 M 2 F

7. Age (In yrs. last birthday)

87

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Feb. 12, 1925

9. Birthplace (State or Foreign Country)

Missouri

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Severn

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

7951 Trafalger Court

10f. Zip Code

21144

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Samuel Scott McBee

18. Mother's Name (First, Middle, Maiden Surname)

Estaline Mae Clevenger

19a. Informant's Name/Relationship (Type, Print)

Richard Hodges : Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9301 Stark Avenue, Kansas City, Missouri 64138

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Woodlawn Cemetery

Date

03/07/2012

20c. Location - City or Town, State

Independence, Missouri

21. Signature of Funeral Service Licensee

► Michael P. Marzullo

22. Name and Address of Facility

Marzullo Funeral Chapel, P.A.
6009 Harford Road, Baltimore, Maryland 21214

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death

2 weeks

Pneumonia

a. Due to (or as a consequence of):

Dementia

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

1 year

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No
9 Unknown

23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (Specify)
9 Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA Other:

26. Place of Death (Check only one)

4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 5 Pending Investigation
2 Accident 6 Could not be determined
3 Suicide
4 Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury M

28c. Injury at work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
only one 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

► Amy Schuler CRNP

29c. License number

L118354

29d. Date signed (Month, Day, Year)

2/28/2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Amy Schuler CRNP 7900 Oak Point Ct Pasadena, MD 21102

31. Date filed (Month, Day, Year)

MAR 14 2012

32. Registrar's Signature

Leanne S. Parker

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
 State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

2012 07926

1- For
State
Registrar

Reg. No.

**Physician
/Medical
Examiner**

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

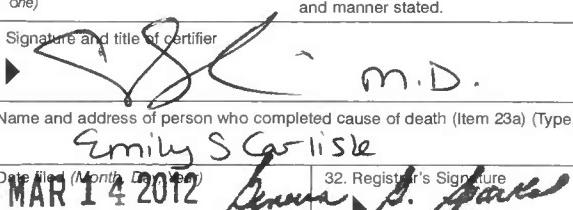
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

		1. Decedent's Name (First, Middle, Last) Bruce Langston				2. Date of Death Month Day Year March 11 2012		3. Time of Death 1918 PM			
		4a. Facility Name (If not institution, give street and number) Johns Hopkins Bayview Medical Center				4b. City, Town, or Location of Death Baltimore		4c. County of Death			
Funeral Director		5. Social Security Number 220-66-0330	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 57 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 10/20/1954		9. Birthplace (State or Foreign Country) Maryland			
		Usual Residence of Decedent 10a. State MD				10b. County Baltimore		10c. City, Town or Location Sparrows Point			
		10e. Street and Number 2112 Oak Road				10f. Zip-Code 21219		10g. Citizen of What Country? USA			
		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Specify:			14. Race - American Indian, Black, White, etc. White		
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Supervisor			16b. Kind of Business/Industry Steel Mill			
		17. Father's Name (First, Middle, Last) James Langston				18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Navratal					
		19a. Informant's Name/Relationship (Type, Print) Kathleen Jane Langston / Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2112 Oak Road, Sparrows Point, MD 21219					
		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Chesapeake Crematory			20b. Place of Disposition (Name of cemetery, crematory or other place)		Date 3/13/2012	20c. Location - City or Town, State Beltsville, MD			
		21. Signature of Funeral Service Licensee Dorota Marshall				22. Name and Address of Facility Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203					
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ASCVD Due to (or as a consequence of): { b. _____ c. _____ d. _____ Approximate Interval Between Onset and Death Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year			
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cardiomyopathy									
		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown									
		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOD		Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		26. Place of Death (Check only one)			
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred				
				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
		29a. Certifier (check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number MD D007 0994							
		29b. Signature and title of certifier  m.d.		29d. Date signed (Month, Day, Year) March 11, 2012							
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Emily S. Garlise									
		31. Date filed (Month, Day, Year) MAR 14 2012									
		32. Registrar's Signature 									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07927

1 - For
State
RegistrarPhysician/
Medical
Examiner

		1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death		
		Lewis Thomas Miller Jr.		Month March Day 11 Year 2012		10:16PM		
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death				
Emeritus Senior Living		Westminster		Carroll				
5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)	
213-44-7142		<input checked="" type="checkbox"/> M <input type="checkbox"/> F	101 Yrs.	Months	Days	1-2-1911	MD	
10a. State		10b. County	10c. City, Town or Location		10d. Inside City Limits			
MD		Carroll	Westminster		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number		10f. Zip Code		10g. Citizen of What Country?				
1012 Oak Dr.		21158		USA				
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)		14. Race - American Indian, Black, White, etc.		
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		Specify: white		
15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry				
Elementary/Secondary (0-12) 12		College (1-4 or 5+) Management Analyst		Government				
17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)						
L. Thomas Miller, Sr.		Henrietta Reichman						
19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)						
L. Thomas Miller -son		1012 Oak Dr., Westminster, MD 21158						
20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date	20c. Location - City or Town, State			
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		South Carroll Crem. 3/13/12		3/13/12	Sykesville, MD			
21. Signature of Funeral Service Licensee		22. Name and Address of Facility						
Thomas D. Fletcher III		Fletcher Funeral Home						
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23c. If yes, outcome of pregnancy		23d. Date of delivery		
{		Dementia		<input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown		Month	Day	Year
23e. Did tobacco use contribute to the cause of death?		23f. Did alcohol contribute to the cause of death?		23g. Did drug use contribute to the cause of death?		23h. Did other medical conditions contribute to the cause of death?		
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
24a. Was an autopsy performed?		24b. Were autopsy findings available prior to completion of cause of death?		24c. Was there a postmortem examination?		24d. Was there a coroner's inquest?		
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner?		26. Place of Death (Check only one)						
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DCA		Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) Hospital Living				
27. Manner of Death		28a. Date of injury (Month, Day, Year)		28b. Time of injury	28c. Injury at work?	28d. Describe how injury occurred		
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		M	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Injury at work?		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier		1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number		29d. Date signed (Month, Day, Year)		
29b. Signature and title of certifier		Kevin Brewster, D.O.		H0055845		3/12/2012		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		32. Registrar's Signature		33. Date filed (Month, Day, Year)				
KEVIN BREWSTER, D.O.		Kevin B. Parker		MAR 14 2012				

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

State
Registrar

5V

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07928

1 - For
State
RegistrarMcCurdy, Florine M488354
Baltimore, Maryland 21215-0036Physician/
Medical
Examiner

1. Decedent's Name (First, Middle, Last) Florine McCurdy				2. Date of Death Month Month Day Year March 13 2012				3. Time of Death 12:06 P M	
4a. Facility Name (if not institution, give street and number) Civista Medical Center				4b. City, Town, or Location of Death La Plata				4c. County of Death Charles	

Funeral
Director

5. Social Security Number 445-38-1198		6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 95 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) 02-23-17	9. Birthplace (State or Foreign Country) OK
---	--	--------------------------	---	---------------------------	--------------------------	---	---

10a. State OK		10b. County Oklahoma		10c. City, Town or Location Oklahoma City				10d. Inside City Limits 1 Yes 2 No
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10e. Street and Number 402 West 18th Street				10f. Zip Code 74447				10g. Citizen of What Country? USA
---	--	--	--	-------------------------------	--	--	--	---

11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:			14. Race - American Indian, Black, White, etc. African American
---	--	--	--	--	---	--	--	---

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Ward Secretary			16b. Kind of Business/Industry Oklahoma Memorial Hospital		
--	--	--	---	--	--	---	--	--

17. Father's Name (First, Middle, Last) Harry Cross, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Birdie House				
--	--	--	--	--	--	--	--	--

19a. Informant's Name/Relationship (Type, Print) Barbara Lynn-Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12210 Crestwood Avenue South Brandywine, MD 20613				
--	--	--	--	---	--	--	--	--

20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Oklahoma Cem.			Date	20c. Location - City or Town, State Oklahoma, OH		
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21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, MD 21217					
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23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Electrolyte disturbance</u> Due to (or as a consequence of): <u>Chronic Renal Failure</u> b. <u>Chronic Renal Failure</u> Due to (or as a consequence of): <u>Hypertension</u> Due to (or as a consequence of): c. <u>Hypertension</u> Due to (or as a consequence of): d. <u></u>								Approximate Interval Between Onset and Death days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								years

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)						23d. Date of delivery Month Day Year		
--	--	--	--	--	--	--	--	---	--	--

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Acute Renal Insufficiency</u> <u>Cardiomyopathy</u> <u>Coronary Artery Disease</u>								23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown		
								24a. Was an autopsy performed? 1 Yes 2 No		
								24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No		

25. Was case referred to medical examiner? 1 Yes 2 No		26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)					
---	--	---	--	--	--	--	--

27. Manner of Death 1 Natural 5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? 1 Yes 2 No	28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)	

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number D46419						29d. Date signed (Month, Day, Year) 3/3/12
--	--	--------------------------------------	--	--	--	--	--	--

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charlene Letchford, MD 5 Garrett Avenue LaPlata, Maryland								20646
--	--	--	--	--	--	--	--	-------

31. Date filed (Month, Day, Year) MAR 14 2012		32. Registrar's Signature 					
---	--	-------------------------------	--	--	--	--	--

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

SV

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07929

1 - For
State
Registrar

Physician/
Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Fr. Thomas Macea, P.O. Box 68760 March 2012
Division of Vital Records, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death
THOMAS G. MACEDA		MARCH 13, 2012		3:40 p m
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
ST. JOHN NEUMANN RESIDENCE		TIMONIUM		BALTIMORE
5. Social Security Number 127-28-1448 Usual Residence of Decedent		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 74 Yrs.	If Under 1 Year Months Days Hours Min. 8. Date of Birth (Month, Day, Year) JUNE 1, 1937
10a. State MD		10b. County BALTIMORE		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number 2300 DULANEY VALLEY ROAD		10f. Zip Code 20193		10g. Citizen of What Country? U.S.A.
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+		16b. Kind of Business/Industry PRIEST CATHOLIC CHURCH
17. Father's Name (First, Middle, Last) JOSEPH CLEMENT MACEDA		18. Mother's Name (First, Middle, Maiden Surname) MARY MCENROE		
19a. Informant's Name/Relationship (Type, Print) REV. GERARD SZYMKOWIAK		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2300 DULANEY VALLEY ROAD, TIMONIUM, MD 21093		
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) RESURRECTION CEM.		Date 3/16/12
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility LILLY & ZEILER INC. FUNERAL HOME 700 S. CONKLING STREET, BALTO., MD 21224		20c. Location - City or Town, State STATEN ISLAND, N.Y.
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ALS				
Approximate Interval Between Onset and Death 1 year				
a. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
b. Due to (or as a consequence of):				
c. Due to (or as a consequence of):				
d. Due to (or as a consequence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes mellitus				
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred
				28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input checked="" type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number R 043580		
29b. Signature and title of certifier 		29d. Date signed (Month, Day, Year) 03-14-2012		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Justine Preis, CRNP 2300 Dulane Valley Rd., Timonium, MD 21093				
31. Date filed (Month, Day, Year) MAR 14 2012		32. Registrar's Signature 		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07930

1 - For State Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Jayden Manning				2. Date of Death Month 3 Day 10 Year 12	3. Time of Death 1706 PM		
	4a. Facility Name (if not institution, give street and number) Univ Maryland Medical Center				4b. City, Town, or Location of Death Baltimore		4c. County of Death MD	
Funeral Director	5. Social Security Number 213-91-0865	6. Sex 1 XM 2 F	7. Age (In yrs. last birthday) Yrs. 26	If Under 1 Year Months 10 Days 26	If Under 24 Hrs. Hours _____ Min. _____	8. Date of Birth (Month, Day, Year) 04 13 2011	9. Birthplace (State or Foreign Country) MD	
To Be Completed by Funeral Director	10a. State MD	10b. County NA	10c. City, Town or Location Baltimore				10d. Inside City Limits 1 Yes 2 No	
	10e. Street and Number 3402 Avondale Ave			10f. Zip Code 21215			10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 XM Never Married 2 F Married 3 F Widowed 4 F Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 F Yes 2 XM No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 F Yes 2 XM No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) N/A		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) N/A			16b. Kind of Business/Industry N/A		
	17. Father's Name (First, Middle, Last) Lawrence Manning			18. Mother's Name (First, Middle, Maiden Surname) Kandace Servance				
	19a. Informant's Name/Relationship (Type, Print) Kandace Servance-Mother		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3402 Avondale Ave, Baltimore, Md 21215					
Physician/ Medical Examiner	20a. Method of Disposition 1 XM Burial 2 F Cremation 3 F Removal from State 4 F Donation 5 F Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Woodlawn		Date 3/17/2012	20c. Location - City or Town, State Woodlawn, Md		
To Be Completed by Physician/Medical Examiner	<p>22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21215</p> <p>23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.</p> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> <p>a. Due to (or as a consequence of): Metabolic acidosis</p> <p>b. Due to (or as a consequence of): Pulmonary hypertension</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p> <p>Approximate Interval Between Onset and Death 12 hours</p> <p>10 mths.</p>							
	23b. Was decedent pregnant in the past 12 months? 1 XM Yes 2 F No 9 F Unknown		23c. If yes, outcome of pregnancy 1 F Live Birth 2 F Fetal death 3 F Ectopic pregnancy 4 F Pregnant at time of death 5 F Other (specify) 9 F Unknown			23d. Date of delivery Month Day Year		
	<p>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</p> <p>23e. Did tobacco use contribute to the cause of death? 1 F Yes 2 XM No 3 F Probably 4 F Unknown</p> <p>24a. Was an autopsy performed? 1 XM Yes 2 F No</p> <p>24b. Were autopsy findings available prior to completion of cause of death? 1 F Yes 2 XM No</p>							
Medical Certificate: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 XM Yes 2 F No		26. Place of Death (Check only one) Hospital: 1 XM Inpatient 2 F ER/Outpatient 3 F DOA		Other: 4 F Nursing Home 5 F Residence 6 F Other (Specify)			
	27. Manner of Death 1 XM Natural 5 F Pending Investigation 2 F Accident 6 F Could not be determined 3 F Suicide 4 F Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 F Yes 2 F No	28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 XM Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 F Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 F Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier Nan Garber, MD		29c. License number D63539			29d. Date signed (Month, Day, Year) 03/10/2012		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nan Garber, MD, 29 S. Greene Street Suite 104, Baltimore, MD 21201							
	31. Date filed (Month, Day, Year) MAR 14 2012		32. Registrar's Signature Susan J. Parker					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

State
Registrar

12-01790

Johnny Mattocks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07931

1. For State Registrar

**Physician/
Medical Examiner****Funeral
Director**

Baltimore, MD 21215-0036
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
 Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a show any
 injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director**Physician/
Medical
Examiner****Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed
 within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and
 completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death 2127 hrs	
Johnny Ace Mattocks		March 2, 2012			
4a. Facility Name (if not institution, give street and number) Johns Hopkins Hospital		4b. City, Town, or Location of Death Baltimore		4c. County of Death	
5. Social Security Number 219-62-1607		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 56 Yrs.	
8. If Under 1 Year Months Days		9. If Under 24 Hrs. Hours Min.		10. Date of Birth (MM/DD/YYYY) 12/2/1955	
10a. State MD		10b. County N/A		10c. City, Town or Location Baltimore	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number 1306 Wharfcoat Street		10f. Zip Code 21217		10g. Citizen of What Country? USA	
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify:	
14. Race - American Indian, Black, White, etc. Specify: Black					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 0		16b. Kind of Business/Industry Mechanic Auto	
17. Father's Name (First, Middle, Last) John Mattocks		18. Mother's Name (First, Middle, Maiden Surname) Evelyn Frye			
19a. Informant's Name/Relationship (Type, Print) Ms. Anita Handy		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1306 Wharfcoat Street Baltimore, MD 21217			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify Odyssey Gray		20b. Place of Disposition (Name of cemetery, crematory or other place) Trinity Cemetery		Date 3/10/12	20c. Location - City or Town, State Dundalk, MD
21. Signature of Funeral Service Licensee Odyssey Gray		22. Name and Address of Facility Joseph L. Russ Funeral Home, P.A. 2222 N. North Ave. Baltimore, MD 21216			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):					
b. _____ Due to (or as a consequence of):					
c. _____ Due to (or as a consequence of):					
d. _____					
<input type="checkbox"/> UNPENDED		<input type="checkbox"/> AMENDED			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Prostate Cancer					
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury	
				28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. one) 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier Ana		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) March 9, 2012	
30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223					
31. Date filed (Month, Day, Year) MAR 14 2012		32. Registrar's Signature Suzanne B. Parker			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07933
Time of Death

Physician/ Medical Examiner		CERTIFICATE OF DEATH						Reg. No.		
		1. Decedent's Name (First, Middle, Last)				2. Date of Death Month Day Year		3. Time of Death 1255 hrs		
		Earl Theodore Mobley				March 2, 2012				
Funeral Director		4a. Facility Name (if not institution, give street and number) 50 Pleasant Street			4b. City, Town, or Location of Death Annapolis			4c. County of Death Anne Arundel		
		5. Social Security Number 214-44-9953	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 64 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (MM/DD/YYYY) 01/17/1948	9. Birthplace (State or Foreign Country) Washington DC		
		Usual Residence of Decedent 10a. State MD				10b. County Anne Arundel			10c. City, Town or Location Annapolis	
		10e. Street and Number 50 Pleasant Street			10f. Zip Code 21403			10g. Citizen of What Country? USA		
To Be Completed by Funeral Director		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Black					
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12	College (1-4 or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Crain Operator	16b. Kind of Business/Industry Construction					
		17. Father's Name (First, Middle, Last) Sydney Mobley	18. Mother's Name (First, Middle, Maiden Surname) Eloise Randolph							
		19a. Informant's Name/Relationship (Type, Print) Tiffanie L. Rich / Daughter	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1732 Appleton Street, Baltimore, MD 21217							
		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify: Dorota Marshall	20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory	Date 3/13/2012	20c. Location - City or Town, State Beltsville, MD					
Physician /Medical Examiner		21. Signature of Funeral Service Licensee Dorota Marshall	22. Name and Address of Facility Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203							
To Be Completed by Physician/Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____						Approximate Interval Between Onset and Death		
		23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown						23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year	
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
		25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No						26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene	24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)		
		29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated						29c. License number O.C.M.E.		
		29b. Signature and title of certifier <i>Ana Rubio</i>						29d. Date signed (Month, Day, Year) March 3, 2012		
		30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223								
State Registrar		31. Date filed (Month, Day, Year) MAR 14 2012			32. Registrar's Signature <i>Ana Rubio</i>					

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Hospital or Att
within 24 hours after de

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2012 07934

Certificate of Death

Reg. No.

1 - For
State
RegistrarPhysician/
Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)		Neal McNeill		2. Date of Death Month Day Year	3. Time of Death
4a. Facility Name (if not institution, give street and number) <i>The Johns Hopkins Hospital</i>		4b. City, Town, or Location of Death <i>Baltimore City</i>		4c. County of Death	
5. Social Security Number <i>242-54-7908</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>72 Yrs.</i>	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) <i>7-16-1939</i>
Usual Residence of Decedent <i>Md</i>		10c. City, Town or Location <i>Baltimore</i>		9. Birthplace (State or Foreign Country) <i>North Carolina</i>	
10a. State <i>Md</i>		10b. County		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <i>2231 Asquith Street</i>		10f. Zip Code <i>21218</i>		10g. Citizen of What Country? <i>USA</i>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Date. <i>1962</i>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <i>Black</i>	
15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Shipping</i>		16b. Kind of Business/Industry <i>Longshoreman</i>	
17. Father's Name (First, Middle, Last) <i>JACK MCNEILL</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>Bedelia</i>			
19a. Informant's Name/Relationship (Type, Print) <i>Robin McNeill</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2 Hespert Rd. Apt G. Nottingham, Md 21236</i>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>Gathering Bullock</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>TRINITY Cemetery</i>		Date <i>3/16/12</i>	20c. Location - City or Town, State <i>BALTO. MD</i>
21. Signature of Funeral Service Licensee <i>Gathering Bullock</i>		22. Name and Address of Facility <i>Holmes Metropolitan Chapel</i>		1639 N. Broadway BALTO. MD. 21215	
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death			
a. Due to (or as a consequence of): <i>Acute Respiratory Distress Syndrome</i>					
b. Due to (or as a consequence of):					
c. Due to (or as a consequence of):					
d. _____					
IF FEMALE:		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		9			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		23f. Did alcohol contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
		<i>March 12, 2012</i>	<i>M</i>		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <i>At home</i>			
29b. Signature and title of certifier <i>Blairin McNamee</i>		29c. License number <i>RES - 000</i>		29d. Date signed (Month, Day, Year) <i>MARCH 12 2012</i>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>BLAIRIN MCNAMEE</i>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <i>600 North Wolfe St, Baltimore, MD 21287</i>			
31. Date filed (Month, Day, Year) <i>MAR 14 2012</i>		32. Registrar's Signature <i>Serge A. Parker</i>			

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Physician or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07935

1 - For
State
RegistrarPhysician/
Medical
Examiner

1. Decedent's Name (First, Middle, Last) MARGARET METZGER				2. Date of Death Month MARCH Day 10 , Year 2012				3. Time of Death 1104AM
4a. Facility Name (if not institution, give street and number) NIGHTINGALE HOSPITAL				4b. City, Town, or Location of Death RANDALLSTOWN				4c. County of Death BALTIMORE
5. Social Security Number 216-50-1904		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 66 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) January 1, 1946	9. Birthplace (State or Foreign Country) Maryland	

Funeral
Director

To Be Completed by Funeral Director

10a. State MD	10b. County	10c. City, Town or Location Baltimore				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number 1542 Boyle Street			10f. Zip Code 21230			10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business Industry Own Home		
17. Father's Name (First, Middle, Last) Oscar Schnauffer				18. Mother's Name (First, Middle, Maiden Surname) Margaret Jones				
19a. Informant's Name/Relationship (Type, Print) Rudy Metzger husband			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1542 Boyle Street Baltimore, MD 21230					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven Memorial Park			Date March 14, 2012	20c. Location - City or Town, State Glen Burnie, Maryland	
21. Signature of Funeral Service Licensee OSM 1270			22. Name and Address of Facility McCully Polyniak Funeral Home, P.A. 130 East Fort Avenue Baltimore, MD 21230					

Baltimore, Maryland 21215-0036
 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland
 Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
 any injury or other traumatic event, the Medical Examiner must be notified at
 once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPSIS		Approximate Interval Between Onset and Death		
b. Due to (or as a consequence of): RENAL FAILURE				
c. Due to (or as a consequence of):				
d. Due to (or as a consequence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		
		23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work? M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred
29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29b. Signature and title of certifier Cliff Farber		29c. License number 0 0024970		29d. Date signed (Month, Day, Year) MARCH 11, 2012
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CLIFF FARBER 5401 120 COURT RD. RANDALLSTOWN, MARYLAND 21133				
31. Date filed (Month, Day, Year) MAR 14 2012		32. Registrar's Signature Suzanne B. Farber		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07936

1- For State Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Earl Mills					2. Date of Death Month March Day 1 , Year 2012	3. Time of Death 1120 hrs		
	4a. Facility Name (if not institution, give street and number) University Hospital					4b. City, Town, or Location of Death Baltimore	4c. County of Death N/A		
Funeral Director	5. Social Security Number 218-76-2603	6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 46 Yrs.	If Under 1 Year Months	If Under 24Hrs. Days	8. Date of Birth (MM/DD/YYYY) 03/18/1965	9. Birthplace (State or Foreign Country) MD		
	Usual Residence of Decedent 10a. State MD 10b. County N/A 10c. City, Town or Location Baltimore					10d. Inside City Limits 1 Yes 2 No			
To Be Completed by Funeral Director	10e. Street and Number 1040 N. Ellamont St.			10f. Zip Code 21216		10g. Citizen of What Country? U.S.A.			
	11. Marital Status 1 X Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 X No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 X No specify: Black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th Grade			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Housekeeper			16b. Kind of Business/Industry Kentucky Fried Chicken			
17. Father's Name (First, Middle, Last) Earl C. Mills				18. Mother's Name (First, Middle, Maiden Surname) Leanna Mason					
19a. Informant's Name/Relationship (Type, Print) Leanna Mason (Mother)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1040 N. Ellamont St., Baltimore, MD 21216					
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 X Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify: <i>Dietrich N. Williams</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) on-site Crematory		Date 03/07/12	20c. Location - City or Town, State Baltimore, MD				
21. Signature of Funeral Service Licensee				22. Name and Address of Facility Joseph H. Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 21217					
Physician / Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Mixed Drug (Cocaine and Morphine) and alcohol Intoxication Due to (or as a consequence of):								
	b. Due to (or as a consequence of):								
c. Due to (or as a consequence of):									
d. _____									
<input checked="" type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED 23a, 27, 28a-f, per me, g925 3-19-12 sm									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month _____ Day _____ Year _____				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
							24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
							24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other:							
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input checked="" type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) fd 3-1-12		28b. Time of Injury fd 10:30 am		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 X No		28d. Describe how injury occurred unknown	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Found: residence		28f. Location (Street and Number or Rural Route Number, City or Town, State) 1004 W. Cross St. Baltimore, MD.							
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier <i>Mills</i>		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) March 2, 2012					
30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223									
31. Date filed (Month, Day, Year) MAR 14 2012		32. Registrar's Signature <i>James S. Parker</i>							

ORIGINAL

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07937

1 - For
State
RegistrarPhysician/
Medical
Examiner

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/
Medical
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death	
<i>Glynda NELSON</i>		March 12, 2012		2:45 P.M.	
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death	
2542 Edmondson Ave		Baltimore			
5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.
213-36-5159		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	76 Yrs.	Months	Days Hours Min.
Usual Residence of Decedent					
10a. State		10b. County		10c. City, Town or Location	
MD		NA		Baltimore	
10e. Street and Number		10f. Zip Code		10g. Citizen of What Country?	
2542 Edmondson Ave		21223		U.S.A.	
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry	
Elementary/Secondary (0-12) 12th grade		College (1-4 or 5+) 5yrs		Claims Technician Social Security Admin	
17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)			
Miles Jones		Mittie Ann Russell			
19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
Janet Douglas-Daughter		4407 Eldone Road, Baltimore, Md 21229			
20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date	20c. Location - City or Town, State
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		Eastside		3/17/2012	Statesboro, GA
21. Signature of Funeral Service Licensee		22. Name and Address of Facility			
<i>Glynda B. Keke</i>		March F/H West 4300 Wabash Ave, Baltimore, Md 21215			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death			
a. Due to (or as a consequence of): <i>pancreatic cancer</i>					
b. Due to (or as a consequence of):					
c. Due to (or as a consequence of):					
d. Due to (or as a consequence of):					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <i>D15872</i>		29d. Date signed (Month, Day, Year) <i>March 13, 2012</i>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)					
<i>Donald Bob 6934 Pincham Blvd Glen Burnie 21061</i>					
31. Date filed (Month, Day, Year)		32. Registrar's Signature			
MAR 14 2012		<i>Laura J. Parker</i>			

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2012 07938

Certificate of Death

Reg. No.

For
State
Registrar

Physician/
Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

1. Decedent's Name (First, Middle, Last) Francis C. Parsons			2. Date of Death Month March Day 13 Year 2012	3. Time of Death 11:14 AM
4a. Facility Name (if not institution, give street and number) 2303 Coon Club Rd.			4b. City, Town, or Location of Death Westminster	
4c. County of Death Carroll				
5. Social Security Number 218-58-6602	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 59 Yrs.	If Under 1 Year Months <input type="checkbox"/>	If Under 24 Hrs. Days <input type="checkbox"/>
8. Date of Birth (Month, Day, Year) 9-29-1952			9. Birthplace (State or Foreign Country) MD	
10a. State MD			10b. County Carroll	
10c. City, Town or Location Westminster			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 2303 Coon Club Rd.			10f. Zip Code 21157	10g. Citizen of What Country? USA
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: white
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 2 Engineer		16b. Kind of Business/Industry Engineering
17. Father's Name (First, Middle, Last) Harvey Parsons Jr.			18. Mother's Name (First, Middle, Maiden Surname) Genevieve King	
19a. Informant's Name/Relationship (Type, Print) Teresa Parsons-wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2303 Coon Club Rd., Westminster, MD 21157	
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) South Carroll Crem		Date 3/15/12
21. Signature of Funeral Service Licensee Thomas O. Fletcher III		22. Name and Address of Facility Fletcher Funeral Home 254 E. Main St., Westminster, MD 21157		

Physician/
Medical
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year	Approximate Interval Between Onset and Death 6/1/11 - present	
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOD Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death Natural <input checked="" type="checkbox"/> Pending Investigation Accident <input type="checkbox"/> Could not be determined Suicide Homicide <input type="checkbox"/>			
28a. Date of injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number D0057256					
29b. Signature and title of certifier Plummer MD		29d. Date signed (Month, Day, Year) 3/14/2012					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pallavi P. Kumar, 9103 Franklin Square Drive, Suite 2200, Baltimore, MD							
31. Date filed (Month, Day, Year) MAR 14 2012		32. Registrar's Signature Leanne S. Pace					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07939

1- For
State
Registrar

Physician/
Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

MARCH 11, 2012 9:40AM
Baltimore, Maryland 21215-0036

MARY POLONESI
Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) MARY KATHERINE POLONESI		2. Date of Death Month MARCH Day 11 Year 2012	3. Time of Death 9:40A M
4a. Facility Name (if not institution, give street and number) HOOPER HOUSE HOSPICE		4b. City, Town, or Location of Death FOREST HILL	
4c. County of Death HARFORD		3. Time of Death 9:40A M	
5. Social Security Number 216-18-6804		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 87 Yrs.
8. Date of Birth (Month, Day, Year) 6-10-1924		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
9. Birthplace (State or Foreign Country) MD.		10. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10a. State Maryland 10b. County Harford		10c. City, Town or Location Bel Air	
10e. Street and Number 128 W. Ring Factory Rd. Apt. 1365		10f. Zip Code 21014	10g. Citizen of What Country? USA
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 yrs.	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) N/A		16b. Kind of Business/Industry Homemaking-Own Home	
17. Father's Name (First, Middle, Last) Jesse Griffith		18. Mother's Name (First, Middle, Maiden Surname) Deborah Lenk	
19a. Informant's Name/Relationship (Type, Print) Michael A. Polonesi (Son)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 701 Cottontale Ct. Bel Air, Md. 21015	
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Parkwood Cemetery	Date 3-14-2012
20c. Location - City or Town, State Baltimore, Md.		21. Signature of Funeral Service Licensee 	
22. Name and Address of Facility Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) END STAGE CARDIAC DISEASE	
23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown	
23d. Date of delivery Month Day Year		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) HOSPICE HOUSE	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M
		28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input checked="" type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number R149792	
29b. Signature and title of certifier 		29d. Date signed (Month, Day, Year) 3/12/2012	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES CRNP 2300 SUANEY VALLEY RD TIMONIUM, MD 21093		32. Registrar's Signature 	
31. Date filed (Month, Day, Year) MAR 14 2012		33. Date signed (Month, Day, Year)	

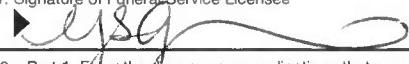
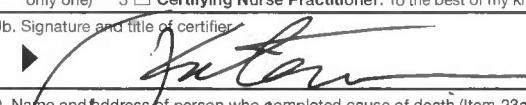
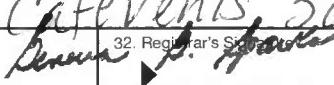
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07940

1 - For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Joyce M. Patton							2. Date of Death Month March	Day 6	Year 2012	3. Time of Death 6:15 PM		
	4a. Facility Name (if not institution, give street and number) Prince George's Hospital							4b. City, Town, or Location of Death Cheverly			4c. County of Death Prince George's		
Funeral Director	5. Social Security Number 105-22-7941		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 89 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) Nov 25 1922	9. Birthplace (State or Foreign Country) Jamaica					
	Usual Residence of Decedent												
10a. State MD		10b. County Prince George's		10c. City, Town or Location Upper Marlboro							10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 13020 Boykin Place		10f. Zip Code 20774							10g. Citizen of What Country? USA				
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Black			14. Race - American Indian, Black, White, etc.				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) LPN Nurse			16b. Kind of Business/Industry Private							
17. Father's Name (First, Middle, Last) Samuel Hylton							18. Mother's Name (First, Middle, Maiden Surname) Mable Green						
19a. Informant's Name/Relationship (Type, Print) Donna Hargrove/ Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8218 Arbor Meadows Lane, Columbia, Maryland 21045									
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Resurrection Cemetery			Date 03/17/2012	20c. Location - City or Town, State Clinton, Maryland					
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility J.B. Jenkins Funeral Home 7474 Landover Road, Landover, Maryland 20785									
<p>23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.</p> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> <p>a. Intracerebral Hemorrhage Due to (or as a consequence of):</p> <p>b. Hypertension Due to (or as a consequence of):</p> <p>c. Multiple myeloma Due to (or as a consequence of):</p> <p>d. _____</p>													
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown							23d. Date of delivery Month Day Year				
<p>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</p> <p>23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown</p> <p>24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>													
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA			Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		26. Place of Death (Check only one)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury		28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29b. Signature and title of certifier 		29c. License number 030318		29d. Date signed (Month, Day, Year) 3/6/12									
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James Cafevens 3001 Hospital Dr Cheverly MD 20785													
31. Date filed (Month, Day, Year) MAR 14 2012		32. Registrar's Signature 											

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07941

1- For
State
RegistrarPhysician/
Medical
ExaminerFuneral
Director

Baltimore, Maryland 21215-0036

Permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last)		PEARSALL				2. Date of Death	3. Time of Death
daron T PEARSALL						Month March Day 8 Year 2012	6:00 AM
4a. Facility Name (if not institution, give street and number)		Howard County General Hospital				4b. City, Town, or Location of Death	4c. County of Death
						Columbia	Howard
5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign Country)
200-14-1675		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	93 Yrs.	Months	Days	Hours	Year
Usual Residence of Decedent						10. Date of Birth (Month, Day, Year)	PA
10a. State	10b. County	10c. City, Town or Location				Jul 7, 1918	
MD	Howard	Columbia					
10e. Street and Number		10f. Zip Code				10g. Citizen of What Country?	
7070 Cradle Rock Way		21045				U.S.A.	
11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			14. Race - American Indian, Black, White, etc.
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.			1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			Specify: Black
15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)				16b. Kind of Business/Industry	
Elementary/Secondary (0-12) 12		Homemaker				Own Home	
17. Father's Name (First, Middle, Last)				18. Mother's Name (First, Middle, Maiden Surname)			
John Teamor				Bertha Crockett			
19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)					
Eve Pearsall daughter-in-law		7140 Winter Rose Path Columbia, MD 21045					
20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)				Date	20c. Location - City or Town, State
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		Atlantic Crematory, LLC				Mar 17, 2012	Glen Burnie, MD
21. Signature of Funeral Service License		22. Name and Address of Facility					
<i>Melody Richey Wright Mar 293</i>		Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043					

Medical Certificate: To Be Completed by Physician/Medical Examiner

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.		23b. Immediate Cause (Final disease or condition resulting in death)		23c. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23d. Approximate Interval Between Onset and Death	
<i>SEPSIS</i>		<i>Colitis</i>		<i>Pneumonia</i>		<i>Congestive Heart Failure</i>	
a. Due to (or as a consequence of):		b. Due to (or as a consequence of):		c. Due to (or as a consequence of):		d. Due to (or as a consequence of):	
IF FEMALE:		23c. If yes, outcome of pregnancy		23d. Date of delivery		23e. Did tobacco use contribute to the cause of death?	
23b. Was decedent pregnant in the past 12 months?		1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown		Month Day Year		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
23f. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		<i>Dementia</i>		23g. Did tobacco use contribute to the cause of death?		23h. Was an autopsy performed?	
23i. Was case referred to medical examiner?		23j. Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		23k. Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		23l. Were autopsy findings available prior to completion of cause of death?	
23m. Manner of Death		23n. Date of injury (Month, Day, Year)		23o. Time of injury		23p. Injury at work?	
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		M		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		23q. Describe how injury occurred	
23r. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		23s. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		23t. Location (Street and Number or Rural Route Number, City or Town, State)			
23u. Signature and title of certifier		23v. License number		23w. Date signed (Month, Day, Year)			
<i>Karen Bell, MS</i>		DS3987		March 8 2012			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		<i>RENNETTE GEFF, MD</i> <i>300 MEMORY PLAZA SUITE 300 BALTIMORE MD 21201</i>					
31. Date filed (Month, Day, Year)		32. Registrar's Signature					
MAR 14 2012		<i>J. S. Parker</i>					

Certificate of Death

Reg. No.

1 - For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Paul A. Peles				2. Date of Death Month Mar Day 9 Year 2012	3. Time of Death 5:45 A M		
	4a. Facility Name (if not institution, give street and number) Heartlands Senior Living Village				4b. City, Town, or Location of Death Ellicott City	4c. County of Death Howard		
Funeral Director	5. Social Security Number 09 196-86-5246	6. Sex M	7. Age (in yrs. last birthday) 96 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Jan 10, 1916	9. Birthplace (State or Foreign Country) PA	
To Be Completed by Funeral Director	Usual Residence of Decedent MD		10b. County Howard	10c. City, Town or Location Ellicott City			10d. Inside City Limits Yes	
	10e. Street and Number 3004 N. Ridge Rd.			10f. Zip Code 21043		10g. Citizen of What Country? U.S.A.		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Steelworker			16b. Kind of Business/Industry Steel Industry		
	17. Father's Name (First, Middle, Last) Joseph Peles				18. Mother's Name (First, Middle, Maiden Surname) Mary Nehila			
	19a. Informant's Name/Relationship (Type, Print) Mr. Paul Peles, Jr.			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10206 Harvest Fields Dr. Woodstock, MD 21163				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Grandview Cemetery		Date Mar 12, 2012	20c. Location - City or Town, State Johnstown, PA		
	21. Signature of Funeral Service Licensee <i>Johnston Lee</i> m00535		22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043					
Physician/ Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)						Approximate Interval Between Onset and Death years	
	a. <i>Atherosclerotic cardiovascular disease</i> Due to (or as a consequence of):							
	b. <i>Diabetes type II</i> Due to (or as a consequence of):							
	c. _____ Due to (or as a consequence of):							
	d. _____ Due to (or as a consequence of):							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
Medical Certificate To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Hypertension</i>						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
							24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <i>Assisted living</i>					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input checked="" type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier <i>Katherine Tantag-Carl</i>		29c. License number R121680			29d. Date signed (Month, Day, Year) March, 9, 2012		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Katherine Tantag-Carl 6334 Cedar Lane Columbia MD 21044</i>							
State Registrar	31. Dated (Month, Day, Year) MAR 14 2012		32. Registrar's Signature <i>Barbara J. Parker</i>					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07943

1 - For
State
Registrar

Physician/
Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

1. Decedent's Name (First, Middle, Last) Ruth Burrell Paine				2. Date of Death Month: March Day: 06 Year: 2012		3. Time of Death 8:08 PM	
4a. Facility Name (if not institution, give street and number) Moningside Assisted Living				4b. City, Town, or Location of Death Ellicott City		4c. County of Death Howard	
5. Social Security Number 029-14-6191		6. Sex X 1 <input type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month/Day/Year) 07/23/1923	9. Birthplace (State or Foreign Country) MA
10a. State MD		10b. County Howard		10c. City, Town or Location Ellicott City			10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
10e. Street and Number 5330 Dorsey Hall Drive				10f. Zip Code 21042		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home	
17. Father's Name (First, Middle, Last) Sydney Burrell				18. Mother's Name (First, Middle, Maiden Surname) Edith A. Brightman			
19a. Informant's Name/Relationship (Type, Print) Ruth M. Paine / Daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11913 Yellow Rush Pass, Columbia, MD 21044				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory		Date 3/13/2012	20c. Location - City or Town, State Beltsville, MD	
21. Signature of Funeral Service Licensee Dorota Marshall <i>Dorota W. Marshall</i>			22. Name and Address of Facility Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203				

Physician/
Medical
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760
To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)			Approximate Interval Between Onset and Death	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Dementia				
{		a. Due to (or as a consequence of):				
		b. Due to (or as a consequence of):				
		c. Due to (or as a consequence of):				
		d. _____				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
					24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
					24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Assisted Living				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
29b. Signature and title of certifier <i>Andrew Lazaris</i>		29c. License number D47447			29d. Date signed (Month, Day, Year) March 17, 2012	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrew Lazaris, 6334 Cedar Lane #103, Columbia, MD 21044						
31. Attest (Month, Day, Year) MAR 14 2012		32. Registrar's signature <i>Leanne J. Spalter</i>				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2012 07944

1- For State Registrar

Reg. No.

Physician/
Medical Examiner

1. Decedent's Name (First, Middle, Last) Henry William Pleasant				2. Date of Death Month March Day 9 Year 2012	3. Time of Death 1825 hrs
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Funeral Director

4a. Facility Name (if not institution, give street and number) Upper Chesapeake Medical Center			4b. City, Town, or Location of Death Bel Air		
5. Social Security Number 219-22-9367			6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. 8. Date of Birth (MM/DD/YYYY) 01/08/1926
					9. Birthplace (State or Foreign Country) North Carolina

To Be Completed by Funeral Director

10a. State MD	10b. County Harford	10c. City, Town or Location Edgewood	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
-------------------------	-------------------------------	--	--

10e. Street and Number 604 Aspen Lane	10f. Zip Code 21040	10g. Citizen of What Country? USA
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11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year Army 1944-47	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White	14. Race - American Indian, Black, White, etc.
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15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Steel Worker	16b. Kind of Business/Industry Steel Mill
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17. Father's Name (First, Middle, Last) Monro Pleasant	18. Mother's Name (First, Middle, Maiden Surname) Lottie Stephens
--	---

19a. Informant's Name/Relationship (Type, Print) Betty Pleasant / Wife	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 604 Aspen Lane, Edgewood, MD 21040
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20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other Specify: Chesapeake Crematory	20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory	Date 3/14/2012	20c. Location - City or Town, State Beltsville, MD
---	---	--------------------------	--

21. Signature of Funeral Service Licensee Dorota Marshall	22. Name and Address of Facility Maryland Cremation Services, PO Box 1413.Baltimore, MD 21203
---	---

Baltimore, MD 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 2a or 2b show any injury or other transmittable event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

State Registrar

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and Death
---	--

Immediate Cause (Final disease or condition resulting in death)	a. Hypertensive Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):
---	---

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. _____ Due to (or as a consequence of):
--	--

c. _____ Due to (or as a consequence of):	d. _____
--	----------

<input type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
--	---	---

23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
--	--

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Multiple rib fractures, Parkinson's dementia	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
---	---	---

25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other:		
---	---	--	--

27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day, Year) Feb 12, 2012	28b. Time of Injury 1800 hrs	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	28d. Describe how injury occurred Subject fell
--	---	--	---	--

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Residence	28f. Location (Street and Number or Rural Route Number, City or Town, State) 604 Aspen Lane, Edgewood, MD
--	---

29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) March 12, 2012
---	--	--

30. Name and address of person who completed cause of death (Item 2a) Melissa Brassell, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223
--

31. Date filed (Month, Day, Year) MAR 14 2012	32. Registrar's Signature Laura J. Brassell
---	---

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No. 2012 07945

1 - For
State
Registrar

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

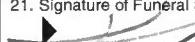
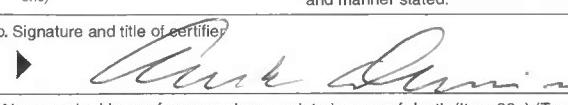
Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		NANCY ELLEN PHILLIPS				2. Date of Death Month Day Year	3. Time of Death 9:40 A M		
4a. Facility Name (If not institution, give street and number) Genesis Eldercare of Hammonds Lane		4b. City, Town, or Location of Death Baltimore				4c. County of Death Anne Arundel			
5. Social Security Number 215-30-0642		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 76 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) June 18, 1935	9. Birthplace (State or Foreign Country) Maryland		
Usual Residence of Decedent 10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 1234 Patapsco St., Apt. 6				10f. Zip Code 21230			10g. Citizen of What Country? USA		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 1		Bookkeeper			16b. Kind of Business/Industry George Krill Co.		
17. Father's Name (First, Middle, Last) Arthur A. Phillips				18. Mother's Name (First, Middle, Maiden Surname) Nellie V. O'Dell					
19a. Informant's Name/Relationship (Type, Print) Mr. Raymond F. Hoffman (Friend)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1297 Limit Avenue, Baltimore, Maryland 21239					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Lorraine Park Cemetery		Date 3/15/2012	20c. Location - City or Town, State Baltimore, Maryland		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility McCullly-Polyniak Funeral Home, P.A. 130 E. Fort Ave., Baltimore, Maryland 21230					
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Dementia								Approximate Interval Between Onset and Death 10 yrs	
b. { Due to (or as a consequence of): Cerebral Vasculitis Seizures c. Due to (or as a consequence of): d. Due to (or as a consequence of): }									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cavernous sinus hemorrhage								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred				
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 						29c. License number D36555	29d. Date signed (Month, Day, Year) March 12, 2012
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alan W. Dennis ms. 801 East Fort Avenue, Baltimore, MD 21230		31. Date filed (Month, Day, Year) MAR 14 2012						32. Registrar's Signature 	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07946

1 - For
State
Registrar

**Physician
/Medical
Examiner**

1. Decedent's Name (First, Middle, Last) Carl Dean Richardson		2. Date of Death Month March		3. Time of Death Day 7 Year 2012
4a. Facility Name (If not institution, give street and number) Harford Memorial Hospital		4b. City, Town, or Location of Death Havre de Grace		4c. County of Death Harford
5. Social Security Number 213-40-1932		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 67 Yrs.	If Under 1 Year Months Days If Under 24 Hrs. Hours Min.
8. Date of Birth (Month, Day, Year) July 28, 1944		9. Birthplace (State or Foreign Country) Maryland		10. Usual Residence of Decedent 10a. State MD
10b. County Harford		10c. City, Town or Location Aberdeen		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
10e. Street and Number 209 Forest Green Rd.		10f. Zip Code 21001		10g. Citizen of What Country? USA
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: white
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 0		16b. Kind of Business/Industry home improvement
17. Father's Name (First, Middle, Last) Glen Breece Richardson		18. Mother's Name (First, Middle, Maiden Surname) Mollie Lee Norman		
19a. Informant's Name/Relationship (Type, Print) Phyllis Richardson - wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 209 Forest Green Rd; Aberdeen, MD 21001		
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date
21. Signature of Funeral Service Licensee Ronald S. Wade, Director		22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) GASTRO INTESTINAL BLEED				
Approximate Interval Between Onset and Death				
a. Due to (or as a consequence of): GASTRO INTESTINAL BLEED				
b. Due to (or as a consequence of):				
c. Due to (or as a consequence of):				
d. Due to (or as a consequence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred
				28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Khalid Puthawala		
		29c. License number D006918		29d. Date signed (Month, Day, Year) 3-8-2012
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Khalid Puthawala 602 S. Atwood Rd. #206 Bel Air, MD 21078				
31. Date filed (Month, Day, Year) MAR 14 2012		32. Registrar's Signature J. Parker		

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician
/Medical
Examiner**

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Richardson, Carl Dean, 3-7-12 03082012-002

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07947

1- For
State
Registrar**Physician/
Medical
Examiner**

		1. Decedent's Name (First, Middle, Last) SADIE L. SURDYKA						2. Date of Death Month MAR Day 9 Year 2012		3. Time of Death 1934 M			
		4a. Facility Name (if not institution, give street and number) Howard County General Hospital						4b. City, Town, or Location of Death Columbia		4c. County of Death Howard			
		5. Social Security Number 217-05-3563		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 91 Yrs.		If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) 08/25/1920	9. Birthplace (State or Foreign Country) MD		
		10a. State MD		10b. County Carroll		10c. City, Town or Location New Windsor		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
		10e. Street and Number 1433 Hallowell Lane				10f. Zip Code 21776				10g. Citizen of What Country? United States			
		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates. 8		13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White		14. Race - American Indian, Black, White, etc. Specify:					
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Own Home			
		17. Father's Name (First, Middle, Last) Salvatore Sabatino				18. Mother's Name (First, Middle, Maiden Surname) Concetta Gugliuzza							
		19a. Informant's Name/Relationship (Type, Print) Patricia M. Coburn - Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2945 Hearthstone Road Ellicott City, MD 21042							
		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) New Cathedral Cem.				20b. Place of Disposition (Name of cemetery, crematory or other place) New Cathedral Cem.		Date 03/15/2012	20c. Location - City or Town, State Baltimore, MD				
		21. Signature of Funeral Service Licensee John Ollie Witzke				22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043							
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)								Approximate Interval Between Onset and Death			
		<p>a. CARDIAC ARRHYTHMIA Due to (or as a consequence of):</p> <p>b. ATHEROSCLEROTIC HEART DISEASE Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>											
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year							
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. GASTROINTESTINAL BLEEDING								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
										24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		26. Place of Death (Check only one)					
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred			
		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier LEONARD RUCK MD		29c. License number 025004		29d. Date signed (Month, Day, Year) MAR 9 2012					
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LEONARD RUCK, HOWARD CO GEN HOSPITAL, COLUMBIA, MD											
		31. Date filed (Month, Day, Year) MAR 14 2012		32. Registrar's Signature Leanne J. Parker									

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07948

1 - For
State
RegistrarPhysician/
Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/
Medical
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

5 V

		1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death	
		<i>Ida Irene Spence</i>		Month	Day	Year	
		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death	
		<i>Prince Georges Hospital</i>		<i>Cheverly</i>		<i>Prince Georges</i>	
		5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
		<i>230-66-3255</i>	<input checked="" type="checkbox"/> M <input type="checkbox"/> F	<i>63</i> Yrs.	Months Days Hours Min.	<i>January 11, 1949</i>	<i>Virginia</i>
		Usual Residence of Decedent		10d. Inside City Limits			
		10a. State <i>Washington, DC</i>		10b. County			
		10c. City, Town or Location		<i>Washington, DC</i>			
		10e. Street and Number		10f. Zip Code	10g. Citizen of What Country?		
		<i>2921 Pennsylvania Ave SE #2</i>		<i>20020</i>	<i>USA</i>		
		11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	
		<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
		<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		If Yes, Give Year or Dates.		14. Race - American Indian, Black, White, etc.	
		15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry	
		<i>Elementary/Secondary (0-12)</i>		<i>Clerk</i>		<i>U.S. Patent: Trademark</i>	
		17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)			
		<i>Paul Andrew Corpew</i>		<i>Martha Jane Berry</i>			
		19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
		<i>Norman Spence - Husband</i>		<i>2921 Pennsylvania Ave SE #2 Washington, D.C. 20020</i>			
		20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State	
		<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State		<i>Metropolitan Crematory</i>	<i>3/17/2012</i>	<i>Alexandria, Virginia</i>	
		<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)					
		21. Signature of Funeral Service Licensee		22. Name and Address of Facility			
		<i>Robert B Baker Jr.</i>		<i>Chinn Funeral Service 2605 S. Shirlington Rd Arlington, Va. 22206</i>			
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.		Approximate Interval Between Onset and Death			
		Immediate Cause (Final disease or condition resulting in death)		<i>Septicemia</i>			
		a. Due to (or as a consequence of):					
		<i>Pneumonia</i>					
		b. Due to (or as a consequence of):					
		<i>Infected sacral ulcer</i>					
		c. Due to (or as a consequence of):					
		d. Due to (or as a consequence of):					
		IF FEMALE:		23c. If yes, outcome of pregnancy			
		23b. Was decedent pregnant in the past 12 months?		<input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy	<input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify)	23d. Date of delivery	
		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Unknown		Month Day Year	
		24. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death?			
		<i>Long standing Diabetes Mellitus</i>		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
		25. Was case referred to medical examiner?		26. Place of Death (Check only one)			
		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA	Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
		27. Manner of Death		28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work?	
		<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined		<input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify)	M	<input type="checkbox"/> Yes <input type="checkbox"/> No	
		3. <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
		29a. Certifier		29c. License number			
		<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
		<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
		<input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
		29b. Signature and title of certifier		29d. Date signed (Month, Day, Year)			
		<i>Phyllis Cumberbatch</i>		<i>2/29/12</i>			
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)					
		<i>Ophnell Cumberbatch 3001 Hospital Dr. Cheverly, MD. 20785</i>					
		31. Date filed (Month, Day, Year)		32. Registrar's Signature			
		<i>MAR 14 2012</i>		<i>James A. Gandy</i>			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

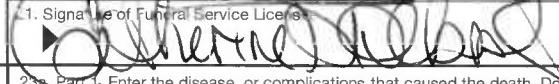
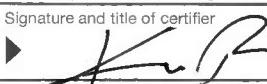
Certificate of Death

Reg. No.

2012 07949

1- For
State
Registrar

Physician/
Medical
Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death Hour Minute AM PM	
Mary J. Smith		March 12, 2012		2:20 AM	
4a. Facility Name (if not institution, give street and number) Anne Arundel Medical Center		4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arundel	
5. Social Security Number 218-28-8657		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.	
8. If Under 1 Year Months Days		9. If Under 24 Hrs. Hours Min.		10. 8. Date of Birth (Month, Day, Year) Sep. 15, 1931	
11. Usual Residence of Decedent Anne Arundel		12. If Yes, Give Year or Dates. If Yes, Give Cuban, Mexican, Puerto Rican, etc.) Year or Dates.		13. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker	
17. Father's Name (First, Middle, Last) Byron Caulford		18. Mother's Name (First, Middle, Maiden Surname) Ruby Halsey		16b. Kind of Business/Industry Own Home	
19a. Informant's Name/Relationship (Type, Print) Rebecca A. Berbig/daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2390 Ginger Drive, Gambrills, MD 21054		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) Metro Crematory	
20b. Place of Disposition (Name of cemetery, crematory or other place)		Date 3-13-2012		20c. Location - City or Town, State Baltimore, MD	
21. Signee of Funeral Service License 		22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy, Bowie, Maryland 20715			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Due to (or as a consequence of): ENCOPRESIS		Approximate Interval Between Onset and Death WEEKS	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23c. Due to (or as a consequence of):			
		23d. Due to (or as a consequence of):			
		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide	
		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	
		28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number 072159	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Kanek R. Patel, 2001 Medical Pkwy, Annapolis, MD 21401				29d. Date signed (Month, Day, Year) 3/12/12	
31. Date filed (Month, Day, Year) MAR 14 2012		32. Registrar's Signature 			

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

Within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07950

1 - For State Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Marquerite Smith							2. Date of Death Month Day Year March 10 2012	3. Time of Death M			
	4a. Facility Name (if not institution, give street and number) Courtland Gardens Nursing Home			4b. City, Town, or Location of Death Pikesville			4c. County of Death Baltimore					
Funeral Director	5. Social Security Number 218-28-6143	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 02 13 33	9. Birthplace (State or Foreign Country) MD					
To Be Completed by Funeral Director	10a. State MD		10b. County NA	10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
	10e. Street and Number 408 Gwynn Ave			10f. Zip Code 21229			10g. Citizen of What Country? U.S.A.					
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerical			16b. Kind of Business Industry Social Security Adm.					
	17. Father's Name (First, Middle, Last) James Smith				18. Mother's Name (First, Middle, Maiden Surname) Thelma Thompson							
	19a. Informant's Name/Relationship (Type, Print) Thelma Brookes-Sister				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2814 Rona Road, Baltimore, Md 21207							
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) King Memorial Park		Date 3/15/2012	20c. Location - City or Town, State Woodlawn, Md						
	21. Signature of Funeral Service Licensee Marguerite B. Keeke		22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21215									
Physician/ Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Acute myocardial infarction								Approximate Interval Between Onset and Death 6 hours			
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown								23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Medical Certificate: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year) March		28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred					
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) At home								28f. Location (Street and Number or Rural Route Number, City or Town, State) Baltimore, MD			
	29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								29b. Signature and title of certifier Marguerite B. Keeke			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUNIL KAPALI 2434 W BELVEDERE AVE BETHESDA MD 20814								29c. License number 044817			
State Registrar	31. Date filed (Month, Day, Year) MAR 14 2012		32. Registrar's Signature Leanne J. Parker			29d. Date signed (Month, Day, Year) March 12 2012						

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 07951

Certificate of Death

Reg. No.

1 - For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Raymond John Sweigart						2. Date of Death Month 03 Day 01 Year 2012	3. Time of Death 0738 a M
	4a. Facility Name (if not institution, give street and number) Joseph Richey Hospice			4b. City, Town, or Location of Death Baltimore		4c. County of Death		
Funeral Director	5. Social Security Number 213-84-0702	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 52 Yrs.	If Under 1 Year Months 	If Under 24 Hrs. Hours 	8. Date of Birth (Month, Day, Year) 03/01/1960	9. Birthplace (State or Foreign Country) MD	
	Usual Residence of Decedent			10a. State MD	10b. County	10c. City, Town or Location Baltimore	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number 116 South Broadway Rm 28			10f. Zip Code 21231			10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mason	16b. Kind of Business/Industry Construction					
	17. Father's Name (First, Middle, Last) Edward Sweigart	18. Mother's Name (First, Middle, Maiden Surname) Gloria G. Holthous						
	19a. Informant's Name/Relationship (Type, Print) Roxane Lipka Sister	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7521 Brightside Ave Rosedale MD 21237						
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Atlantic Crem	20b. Place of Disposition (Name of cemetery, crematory or other place) Atlantic Crem	Date 3/2/2012	20c. Location - City or Town, State Glen Burnie MD				
Physician/ Medical Examiner	21. Signature of Funeral Service Licensee 	22. Name and Address of Facility Simplicity Crem & Fun Serv ThomasAllenPA 7090 Ridge Rd Hanover MD						
To Be Completed by Physician/Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)			Approximate Interval Between Onset and Death 15 yrs				
	a. HIV - AIDS Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____							
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. COPD			23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown				
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide	28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier 			29c. License number D18587		29d. Date signed (Month, Day, Year) MAR 1 2012		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul Gormley 900 Caton Ave Baltimore, MD 21229							
	31. Date filed (Month, Day, Year) MAR 14 2012	32. Registrar's Signature 						

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

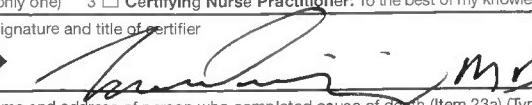
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2012 07952

Reg. No.

1- For
State
Registrar2. Date of Death
Month Day Year
MARCH 8, 20123. Time of Death
10:25 AM

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) DORIS O. STINEBAUGH							2. Date of Death Month Day Year MARCH 8, 2012	3. Time of Death 10:25 AM	
	4a. Facility Name (if not institution, give street and number) SAINT JOSEPH MEDICAL CENTER				4b. City, Town, or Location of Death TOWSON			4c. County of Death BALTIMORE		
Funeral Director	5. Social Security Number 220-24-1792		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 83	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 5/31/1928	9. Birthplace (State or Foreign Country) MARYLAND		
	10a. State MD		10b. County N/A	10c. City, Town or Location Baltimore City				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 524 N. CHARLES STREET APT. 1315				10f. Zip Code 21201			10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10TH GRADE				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) DIETARY TECH.			16b. Kind of Business/Industry JOHNS HOPKINS		
	17. Father's Name (First, Middle, Last) ROLAND MCQUAY					18. Mother's Name (First, Middle, Maiden Surname) ANNABELL GRAY				
	19a. Informant's Name/Relationship (Type, Print) JUDY MCQUAY/SISTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1701 F ABERDEEN ROAD BALTIMORE, MD 21234					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) MEADOWRIDGE MEM. PARK		Date 3/12/2012	20c. Location - City or Town, State ELKRIDGE, MD		
	21. Signature of Funeral Service Licensee Health Hayes				22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286					
Physician/ Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CRITICAL AORTIC STENOSIS								Approximate Interval Between Death and Death UNKNOWN	
	<p>a. Due to (or as a consequence of): CRITICAL AORTIC STENOSIS</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. GASTROINTESTINAL BLEEDING								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
									24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		26. Place of Death (Check only one)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred			
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> only one <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								29b. Signature and title of certifier 	
	29c. License number D0072540								29d. Date signed (Month, Day, Year) 03/08/12	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JONATHAN DAINING, M.D. 7601 OSLER DRIVE TOWSON, MD 21204								31. Date filed (Month, Day, Year) MAR 14 2012	
	32. Registrar's Signature 									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07953

1- For
State
Registrar**Physician/
Medical
Examiner**

1. Decedent's Name (First, Middle, Last) Gaylon Lewis Sowards, Sr.		2. Date of Death Month March Day 10 Year 2012	3. Time of Death 3:22 A M		
4a. Facility Name (if not institution, give street and number) 201 Bengies Road		4b. City, Town, or Location of Death Middle River			
4c. County of Death Baltimore					
5. Social Security Number 217-38-9401		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 70 Yrs.		
Usual Residence of Decedent 10a. State MD 10b. County Baltimore		If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.		
10c. City, Town or Location Middle River		8. Date of Birth (Month Day Year) 10/29/1941			
10e. Street and Number 201 Bengies Road		10f. Zip Code 21220	10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates. Elementary/Secondary (0-12) 12	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: White	14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Lift Truck Driver	16b. Kind of Business/Industry Manufacture		
17. Father's Name (First, Middle, Last) Cleveland Sowards		18. Mother's Name (First, Middle, Maiden Surname) Madeline Knight			
19a. Informant's Name/Relationship (Type, Print) Arlene Sowards / Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 201 Bengies Road, Middle River, MD 21220			
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) Chesapeake Crematory		20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory	Date 3/13/2012		
21. Signature of Funeral Service Licensee Dorota Marshall		22. Name and Address of Facility Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203			
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death			
a. Due to (or as a consequence of): HEAD & NECK CANCER					
b. Due to (or as a consequence of):					
c. Due to (or as a consequence of):					
d. Due to (or as a consequence of):					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown			
23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DCA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier JACKIE JONES CNP		29c. License number R149792		29d. Date signed (Month, Day, Year) 3/10/2012	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES CNP 2300 DULANEY VALLEY RD TOWSON MD 21093					
31. Date filed (Month, Day, Year) MAR 14 2012		32. Registrar's Signature Leanne S. Jones			

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.State
RegistrarBaltimore, Maryland 21215-0036
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

10 ✓

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07954

1- For State Registrar**Physician/
Medical Examiner****Funeral
Director****To Be Completed by Funeral Director****Baltimore, MD 21215-0036**

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last)

Robert L. Skinner

2. Date of Death

Month Day Year

March 3, 2012

3. Time of Death

0159 hrs

4a. Facility Name (if not institution, give street and number)

Saint Agnes Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

212-04-4485

6. Sex

 M F

7. Age (In yrs. last birthday)

30

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth (MM/DD/YYYY)

04-02-1981

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

 Yes No

10e. Street and Number

723 YALE AVE

10f. Zip Code

21228

10g. Citizen of What Country?

U.S.A.

11. Marital Status

 Never Married Married Widowed Divorced

12. Was Decedent Ever in U.S. Armed Forces?

 Yes No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

 Yes No

Specify:

14. Race - American Indian, Black, White, etc.

Specify: AFRICAN-AMER.

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

CHEF

16b. Kind of Business/Industry

RESTAURANT

17. Father's Name (First, Middle, Last)

UNKNOWN

18. Mother's Name (First, Middle, Maiden Surname)

DEANA SKINNER

19a. Informant's Name/Relationship (Type, Print)

MOTHER JOHANNA ROBERTA KIRKLAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

660 POOL DR., APT. 201, HARRISBURG, PA. 17109

20a. Method of Disposition

 Burial Cremation Removal from State Donation Other Specify

20b. Place of Disposition (Name of cemetery, crematory or other place)

PAXTANG CEMETERY

Date

03-15-2012

20c. Location - City or Town, State

PAXTANG, PA.

21. Signature of Funeral Service Licensee

JILL O'Hearn

22. Name and Address of Facility

PHILLIPS FUNERAL HOME

1721 N. MONROE ST. BALTIMORE, MD.

23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Asthma

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

 UNPENDED AMENDED

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown

23c. If yes, outcome of pregnancy

1 Live birth2 Fetal death3 Ectopic pregnancy4 Pregnant at time of death5 Unknown

23d. Date of delivery

Month Day Year

24e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

26. Place of Death (Check only one)

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other:

27. Manner of Death

1 Natural2 Accident3 Suicide4 Homicide5 Pending Investigation6 Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 Yes 2 No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Ana Rubio MD

Assistant Medical Examiner

900 W. Baltimore Street, Baltimore, MD 21223

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

March 3, 2012

30. Name and address of person who completed cause of death (Item 23a)

Ana Rubio MD

Assistant Medical Examiner

900 W. Baltimore Street, Baltimore, MD 21223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07955

1 - For
State
Registrar

Physician/
Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

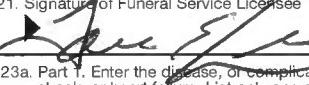
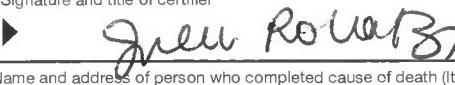
Baltimore, Maryland 21215-0036
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completed filled in by the funeral director, page 2 should be detached for use as the burial-transit
ticket.

Medical Certificate: To Be Completed by Physician/Medical Examiner

Physician
Medical
Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
CHARLES SAY SCOTT		Month	Day	Year
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
8712 TEMPLE HILLS ROAD		TEMPEL HILLS		PRINCE GEORGE'S
5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	8. Date of Birth
578-22-4168		1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	89 Yrs.	Month Day Year FEBRUARY 28, 2012
9. Birthplace (State or Foreign Country)		10. Inside City Limits		
		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10a. State		10b. County	10c. City, Town or Location	
MARYLAND		PRINCE GEORGE'S	TEMPEL HILLS	
10e. Street and Number		10f. Zip Code		10g. Citizen of What Country?
8712 TEMPLE HILLS ROAD		20748		U.S.A.
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces? 043-46		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates. WW-II		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business Industry
Elementary/Seconday (0-12) 12th		College (1-4 or 5+) Pasteurizer		Private Industry
17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)		
EDWARD SCOTT		(unav.)		
19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)		
CHARLES SCOTT (SON)		15110 BLACKBURN ROAD, BURTONSVILLE, MD 20866		
20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Date
1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		MD Veterans Cemetery		03-14-2012
21. Signature of Funeral Service Licensee		22. Name and Address of Facility		
		CEDAR HILL FUNERAL HOME 4111 PENNSYLVANIA AVENUE, SUITLAND, MD 20746		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				
Immediate Cause (Final disease or condition resulting in death)				
a. CARDIO-PULMONARY ARREST Due to (or as a consequence of): DIABETES MELLITUS TYPE II				
b. Due to (or as a consequence of): ESSENTIAL HYPERTENSION				
c. Due to (or as a consequence of):				
d.				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown		
23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
ADVANCED DEMENTIA				
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29d. Date signed (Month, Day, Year)		
29b. Signature and title of certifier 		29c. License number MD# 0101234617		MARCH 13, 2012
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JUHI G. ROHATGI, M.D., VAMC, 50 IRVING STREET NW, WASHINGTON, DC 20422/688				
31. Date filed (Month, Day, Year)		32. Registrar's Signature		
MAR 14 2012				

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07956

1 - For State Registrar		1. Decedent's Name (First, Middle, Last) Denitra Annette Scott					2. Date of Death Month 03 Day 10 Year 2012	3. Time of Death 3:19 PM		
Physician/ Medical Examiner		4a. Facility Name (if not institution, give street and number) Union Memorial Hospital			4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A			
Funeral Director		5. Social Security Number 213-84-5304	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) 49 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 01/28/1963	9. Birthplace (State or Foreign Country) Maryland			
To Be Completed by Funeral Director		10a. State MD		10b. County Baltimore Co.	10c. City, Town or Location Parkville			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
		10e. Street and Number 30 Maple Hollow Ct.			10f. Zip Code 21234		10g. Citizen of What Country? U.S.A.			
		11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black		
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Dispatching Supervisor			16b. Kind of Business/Industry Emergency Medical Transportation		
		17. Father's Name (First, Middle, Last) Edward R. Scott Jr.			18. Mother's Name (First, Middle, Maiden Surname) Shirley Dixon					
		19a. Informant's Name/Relationship (Type, Print) Aenea Madison (daughter)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 Venus Ct. Apt G, Parkville, MD 21234					
		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) on-site Crematory		Date 13/13/12	20c. Location - City or Town, State Baltimore, MD		
		21. Signature of Funeral Service Licensee Derrick N. Williams			22. Name and Address of Facility Joseph H. Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 21217					
Physician/ Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)							Approximate Interval Between Onset and Death 1 year	
		a. <u>Metastatic adenocarcinoma of the lung</u> Due to (or as a consequence of):								
		b. _____ Due to (or as a consequence of):								
		c. _____ Due to (or as a consequence of):								
		d. _____ Due to (or as a consequence of):								
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
Medical Certificate: To Be Completed by Physician/Medical Examiner		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
									24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
									24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred			
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
		29b. Signature and title of certifier Bassem Khalil MD		29c. License number AT 2438946			29d. Date signed (Month, Day, Year) 03, 10, 2012			
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201 E. University PKWY Baltimore MD 21218		31. Date filed (Month, Day, Year) MAR 14 2012			32. Registrar's Signature Bassem J. Khalil			

Reg. No

2012 07957

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) James Francis Tully							Reg. No.	2. Date of Death Month Day Year March 4, 2012	3. Time of Death 1515 hrs	
	4a. Facility Name (if not institution, give street and number) 2738 Cox Neck Road				4b. City, Town, or Location of Death Chester			4c. County of Death Queen Anne's			
Funeral Director	5. Social Security Number 206-20-0970		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (in yrs. last birthday) 85	Yrs.	If Under 1 Year Months Days Hours Min.	If Under 24 Hrs. Hours Min.	8. Date of Birth (MM/DD/YYYY) May 30, 1926	9. Birthplace (State or Foreign Country) Massachusetts		
	10a. State MD		10b. County Queen Anne's		10c. City, Town or Location Chester			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number 2738 Cox Neck Road					10f. Zip Code 21619			10g. Citizen of What Country? USA			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Program Analyst			16b. Kind of Business/Industry Social Security Administration						
17. Father's Name (First, Middle, Last) James F. Tully, Sr.					18. Mother's Name (First, Middle, Maiden Surname) Evangeline Mickler						
19a. Informant's Name/Relationship (Type, Print) James F. Tully, III Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 301 Locust Drive; Catonsville, MD 21228							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify <i>M Dyer no 1234</i>			20b. Place of Disposition (Name of cemetery, crematory or other place) Crownsville VA Cem.			Date 3/9/2012	20c. Location - City or Town, State Crownsville, MD				
21. Signature of Funeral Service Licensee <i>M Dyer no 1234</i>										22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc 1630 Edmondson Avenue; Catonsville, MD 21228	
Physician Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Atherosclerotic Cardiovascular Disease Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____										Approximate Interval Between Onset and Death
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
23b. If FEMALE: 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) _____ 9 <input type="checkbox"/> Unknown											23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No											26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other Scene
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)										28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated one) 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated											
29b. Signature and title of certifier <i>John Brassell, MD</i>					29c. License number O.C.M.E.			29d. Date signed (Month, Day, Year) March 5, 2012			
30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223											
31. Date filed (Month, Day, Year) MAR 14 2012		32. Registrar's Signature <i>James S. Parks</i>									
State Registrar											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07958

1 - For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) FRANK RICHARD TESAR, JR.							2. Date of Death Month Mar. Day 9 Year 2012			3. Time of Death 4:50A M				
	4a. Facility Name (If not institution, give street and number) GILCHRIST CENTER							4b. City, Town, or Location of Death TOWSON			4c. County of Death BALTIMORE				
Funeral Director	5. Social Security Number 215-24-6402		6. Sex M	7. Age (In yrs. last birthday) 82	Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	Hours	Min.	8. Date of Birth (Month, Day, Year) Nov. 11, 1929	9. Birthplace (State or Foreign Country) Maryland				
	10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Baltimore County						10d. Inside City Limits 1 Yes 2 No				
	10e. Street and Number 1719 Daytona Rd.					10f. Zip Code 21234			10g. Citizen of What Country? USA						
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Date KOREAN			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White						
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Pipe Fitter					16b. Kind of Business/Industry Shipyard					
	17. Father's Name (First, Middle, Last) Frank Richard Tesar, Sr.					18. Mother's Name (First, Middle, Maiden Surname) Catherine Schroeder									
	19a. Informant's Name/Relationship (Type, Print) Mary E. Tesar (Wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1719 Daytona Rd. Baltimore, Md. 21234										
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Parkwood Cemetery			Date 3-12-2012	20c. Location - City or Town, State Baltimore, Md.						
	21. Signature of Funeral Service Licensee E. J. Leeschel				22. Name and Address of Facility Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236										
Physician/ Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) metastatic adenocarcinoma										Approximate Interval Between Onset and Death months				
	<p>a. Due to (or as a consequence of): Probable Inv Primary</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>														
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown							23d. Date of delivery Month Day Year					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23e. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
											24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA			Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospital			27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of injury (Month, Day, Year) 28b. Time of injury M		28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
											28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number D 58303							29d. Date signed (Month, Day, Year) MARCH 9 2012					
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANNE J CHARLES MD 6701 N. Charles ST TOWSON MD														
	31. Date filed (Month, Day, Year) MAR 14 2012			32. Registrar's Signature James J. Jaschinski											

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
~~amend 29d, per phy, g925 3-14-12 sm~~
State of Maryland / Department of Health and Mental Hygiene

For
State
Registrar

Certificate of Death

Reg. No. 2012 07959

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) Ruth Ann Tilgham	2. Date of Death Month 02 Day 24 Year 2012	3. Time of Death 9:45 a.m.						
Funeral Director		4a. Facility Name (If not institution, give street and number) 5315 Columbia Road Unit 1A	4b. City, Town, or Location of Death Columbia	4c. County of Death Howard						
To Be Completed by Funeral Director		5. Social Security Number 214-44-3174	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 66 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) 01 07 46	9. Birthplace (State or Foreign Country) DC		
		Usual Residence of Decedent MD Howard	10a. State MD	10b. County Howard	10c. City, Town or Location Columbia				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		10e. Street and Number 5315 Columbia Road Unit 1A	10f. Zip Code 21044				10g. Citizen of What Country? U.S.A.			
		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Black			14. Race - American Indian, Black, White, etc. Specify: Black	
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) na House Keeping			16b. Kind of Business/Industry Greenway Motel	
		17. Father's Name (First, Middle, Last) William Garfield Tilgham				18. Mother's Name (First, Middle, Maiden Surname) Margaret Ruth Thomas				
		19a. Informant's Name/Relationship (Type, Print) Glenwood Brogden-Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5315 Columbia Road Unit 1A, Columbia, Md 21044				
		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) King Memorial Park		Date 3/1/2012	20c. Location - City or Town, State Woodlawn, Md	
21. Signature of Funeral Service Licensee Rene Thompson		22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21215								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Chronic respiratory failure								Approximate Interval Between Onset and Death 2 years		
b. Due to (or as a consequence of): COPD								>10 years		
c. Due to (or as a consequence of): Morbid obesity								>10 years		
d.										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Congestive heart failure hypertension obstructive sleep apnea								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital:		26. Place of Death (Check only one) <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		23f. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred				
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input type="checkbox"/> Medical Examiner <input checked="" type="checkbox"/> Certifying Nurse Practitioner		29b. Signature and title of certifier Sandra M. Nettuno CRNP R109061								
		29c. License number 318/2012 March 2012								
30. Name and address of person who completed cause of death (Item 2a) (Type, Print) 5450 Knoll North Dr. Columbia MD 21045		31. Date filed (Month, Day, Year) MAR 14 2012								
		32. Registrar's Signature Sandra S. Parker								

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

te
ar

State
egistrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07960

1- For
State
Registrar

Physician/
Medical
Examiner

Funeral
Director

Baltimore, Maryland 21215-0036
Permit: Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) <i>Edward Terry</i>			2. Date of Death Month March Day 09 Year 2012	3. Time of Death Hour 0355 M
4a. Facility Name (if not institution, give street and number) <i>Northwest Hospital ER-7</i>			4b. City, Town, or Location of Death <i>Randallstown</i>	
4c. County of Death <i>Baltimore</i>				
5. Social Security Number 239-34-9640	6. Sex M	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours
			Min.	8. Date of Birth (Month, Day, Year) 04/03/1927
			9. Birthplace (State or Foreign Country) N.C.	
10a. State MD			10b. County Baltimore	
10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 1190 W. Northern Parkway			10f. Zip Code 21210	10g. Citizen of What Country? USA
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Black	
15. Decedent's Education (Specify only highest grade completed) 12th			16a. Decedent's Usual Occupation (Give name of work done during most of working life. DO NOT use retired) Union Rep.	
Elementary/Secondary (0-12)			16b. Kind of Business Industry Eastern Stainless Steel Co.	
17. Father's Name (First, Middle, Last) Evans Terry			18. Mother's Name (First, Middle, Maiden Surname) Lillie Crouch	
19a. Informant's Name/Relationship (Type, Print) Corine J. Terry (wife)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1307 E. 36th St. Balto, Md. 21218	
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland National	Date Mar.15, 2012
21. Signature of Funeral Service Licensee 			20c. Location - City or Town, State Laurel, MD	
			21. Name and Address of Facility Calvin B. Scruggs Funeral Home 1412 E. Preston St. Balto, Md. 21213	

Division of Vital Records, P.O. Box 68760
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

10V

State
Registrar

Medical Certificate: To Be Completed by Physician/Medical Examiner

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Arhythmia		Approximate Interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Myocardial infarction		
c. Due to (or as a consequence of): coronary artery disease		
d. Due to (or as a consequence of): diabetes		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. hypertension, high grade urothelial cancer right retroperitoneal abscess		
		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year) 28b. Time of injury M 28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		28f. Location (Street and Number or Rural Route Number, City or Town, State)
29b. Signature and title of certifier 		29c. License number d0068783
		29d. Date signed (Month, Day, Year) March 09, 2012
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael Dewitt MD, Northwest Hospital ER-7		
31. Date filed (Month, Day, Year) MAR 14 2012		
32. Registrar's Signature 		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 07961

Certificate of Death

Reg. No.

1 - For
State
Registrar

1. Decedent's Name (First, Middle, Last)

Samuel Gordon Vonella

2. Date of Death

Month Day Year
MARCH 10, 2012

3. Time of Death

11:15 PM

Physician/
Medical
Examiner

4a. Facility Name (if not institution, give street and number)

3726 CLARENCE II RD.

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

220-20-4317

6. Sex

M F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days Hours Min.

8. Date of Birth

(Month Day Year)
6-12-27

9. Birthplace (State or Foreign Country)

MD

To Be Completed by Funeral Director

Permit: Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Usual Residence of Decedent

10a. State **MD**

10b. County

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

Yes No

10e. Street and Number

3726 CLARENCE II RD.

10f. Zip Code

21229

10g. Citizen of What Country?

U.S.A.

11. Marital Status

Never Married Married
 Widowed Divorced

12. Was Decedent Ever in U.S. Armed Forces?

Yes No
If Yes, Give Year or Dates: **1944-46**

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Yes No Specify:

14. Race - American Indian, Black, White, etc.

Specify: **white**

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

PAPER CUTTER

16b. Kind of Business Industry

PRINTING CO.

17. Father's Name (First, Middle, Last)

Paul Vonella

18. Mother's Name (First, Middle, Maiden Surname)

VIOLA MAY HOWARD

19a. Informant's Name/Relationship (Type, Print)

GERALDINE VONELLA, WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3726 CLARENCE II RD. BALTIMORE, MD. 21229

20a. Method of Disposition

Burial Cremation Removal from State
 Donation Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

W. ARUNDEL CREMATORY 3-13-12 O'DENTON, MD.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

S. D. DeGraw

22. Name and Address of Facility

DAUGHERTY FUNERAL HOME 2601 MOUNTAIN RD. PASADENA, MD. 21122

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. **Rectal Cancer**
Due to (or as a consequence of):

Approximate Interval Between Onset and Death, 5 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. _____
Due to (or as a consequence of):

c. _____
Due to (or as a consequence of):

d. _____

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
 Yes No
 Unknown

23c. If yes, outcome of pregnancy
 Live Birth Fetal death Ectopic pregnancy
 Pregnant at time of death Other (Specify)
 Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

Yes No Probably Unknown

25. Was case referred to medical examiner?

Yes No

Hospital:

Inpatient ER/Outpatient DOA

Other:

Nursing Home Residence Other (Specify)

27. Manner of Death

Natural Pending Investigation
 Accident Could not be determined
 Suicide
 Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work?

Yes No

28d. Describe how injury occurred

M
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Sharon J. McCormack RN

29c. License number

D38762

29d. Date signed (Month, Day, Year)

03-13-12

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5411 Old Frederick Rd. Suite 18 Baltimore, Md. 21229

Sharon J. McCormack RN

31. Date filed (Month, Day, Year)

MAR 14 2012

32. Registrar's Signature

Sharon J. McCormack RN

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Samuel Gordon Vonella

Baltimore, Maryland 21215-0036

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Items 21,22 per th, g925,03/14/2012dhh
State of Maryland Department of Health and Mental Hygiene
For State Amend Item 26 per verb., g925,03/05/2012dhh
Registrar Certificate of Death

Reg. No.

2012 07962

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month Day Year	3. Time of Death
	Gwendolyn C. Williams				01-28-2012	0642 A M
Funeral Director	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death	
	Washington Adventist Hospital		Takoma Park		Montgomery	
To Be Completed by Funeral Director	5. Social Security Number	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. 75	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 10-13-1936	9. Birthplace (State or Foreign Country) Wash. DC
	Usual Residence of Decedent 10a. State MD		10b. County PG		10c. City, Town or Location Hyattsville	
	10e. Street and Number 6060 Sargent Road #5103		10f. Zip Code 20782		10g. Citizen of What Country? US	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 yrs		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Administrative Assist. Federal Trade Com.		16b. Kind of Business Industry	
	17. Father's Name (First, Middle, Last) Thomas N. Corbett		18. Mother's Name (First, Middle, Maiden Surname) Louise Talbert			
Physician/ Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Gwenal Bolding		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5236 Kenstan Dr. Temple Hills, Md. 20748		20c. Location - City or Town, State Beltsville, MD	
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Chesapeake Crem.		20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crem.		Date 01-30-12	20c. Location - City or Town, State Beltsville, MD
Medical Certificate: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Victor C. March, SR		22. Name and Address of Facility Robert G. Mason Marshall March Funeral Home of MD Inc., 4308 Suitland Rd. Suitland, MD 20746, SE		Washington, DC 20026	
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death	
23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year				
23e. Did tobacco use contribute to the cause of death? Diabetes		23e. Did tobacco use contribute to the cause of death? Diabetes		23e. Did tobacco use contribute to the cause of death? Diabetes		
23f. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		23g. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		23h. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)		28b. Time of injury M		
28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier MD		29c. License number 00069081		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7600 Carroll Ave Takoma Park MD Brian Tenney MD		31. Date filed (Month, Day, Year) MAR 05 2012		32. Registrar's Signature Frank J. Parker		

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

H 26, 21, 22
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07963

1 - For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) CHERYL WATTS					2. Date of Death Month MARCH 6 Day 2012 Year		3. Time of Death 7:14 A M		
	4a. Facility Name (if not institution, give street and number) 2974 SIWANOV DRIVE					4b. City, Town, or Location of Death EDGEWOOD		4c. County of Death HARFORD		
Funeral Director	5. Social Security Number 215-92-5841		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) 59 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) AUG. 25 1952	9. Birthplace (State or Foreign Country) GUYANA		
	10a. State MD		10b. County HARFORD		10c. City, Town or Location EDGEWOOD		10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
To Be Completed by Funeral Director	10e. Street and Number 2974 SIWANOV DRIVE				10f. Zip Code 21040		10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CUSTOMER SERVICE REP.		16b. Kind of Business/Industry PRIVATE				
17. Father's Name (First, Middle, Last) CEDRIC WALCOTT					18. Mother's Name (First, Middle, Maiden Surname) ELSIE FIGUERA					
19a. Informant's Name/Relationship (Type, Print) MICHELLE WATTS/DGT.				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2974 SIWANOV DRIVE EDGEWOOD, MARYLAND 21040						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) GATE OF HEAVEN		Date 3/10/2012	20c. Location - City or Town, State SILVER SPRING, MARYLAND			
21. Signature of Funeral Service Licensee Daphney N. Cornelius				22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785						
Physician/ Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death	
	<p>a. Due to (or as a consequence of): <i>Congestive Heart Failure</i></p> <p>b. Due to (or as a consequence of): <i>Coronary Artery Disease</i></p> <p>c. Due to (or as a consequence of):</p> <p>d. _____</p>									
Medical Certificate: To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier 		29c. License number D68235					29d. Date signed (Month, Day, Year) MARCH 9, 2012			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROBERT J. ISHAK M.D. 520 UPPER CHEASPEAKE DRIVE #308 BEL AIR, MARYLAND 21014										
31. Date filed (Month, Day, Year) MAR 14 2012		32. Registrar's Signature 								

Baltimore, Maryland 21215-0036

6

Division of Vital Records, P.O. Box 68760
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

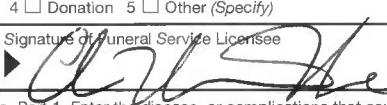
Certificate of Death

Reg. No.

2012 07964

1- For
State
Registrar

Physician/
Medical
Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death	
Mary Catherine Wheltle		Month Day Year March 11, 2012		5:00 P.M.	
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death	
St. Elizabeth Nursing Home		Baltimore			
5. Social Security Number 215-22-3683		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F 83 Yrs.		7. Age (In yrs. last birthday) If Under 1 Year Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Dec. 14, 1928	
Usual Residence of Decedent		10a. State MD		10b. County Howard	
10c. City, Town or Location Ellicott City		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number 2970 Heartstone Road		10f. Zip Code 21042		10g. Citizen of What Country? USA	
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Secretary		16b. Kind of Business/Industry Sun Life Insurance Co.	
17. Father's Name (First, Middle, Last) Francis M. Wheltle		18. Mother's Name (First, Middle, Maiden Surname) Margaret McGee			
19a. Informant's Name/Relationship (Type, Print) Marian Wheltle Niece		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2970 Heartstone Road; Ellicott City, MD 21042			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) New Cathedral Cemetery		Date 3/16/2012	20c. Location - City or Town, State Baltimore, MD
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Due to (or as a consequence of): Cerebrovascular Accident		Approximate Interval Between Onset and Death 2 weeks	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. Due to (or as a consequence of):			
{		b. Due to (or as a consequence of):			
{		c. Due to (or as a consequence of):			
{		d. Due to (or as a consequence of):			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of Certifier 		29c. License number 023355		29d. Date signed (Month, Day, Year) March 12, 2012	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Patrick W. White Jr., 405 Frederick Rd. #202, Baltimore MD 21228					
31. Date filed (Month, Day, Year) MAR 14 2012		32. Registrar's Signature 			

ORIGINAL

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State
Registrar

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07965

1 - For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Carmena</i>							2. Date of Death Month <i>March</i> Day <i>11</i> Year <i>2012</i>	3. Time of Death A.M. <i>09:15</i> P.M. <i>M</i>				
	4a. Facility Name (if not institution, give street and number) <i>Merry Medical Center</i>			4b. City, Town, or Location of Death <i>Baltimore City</i>			4c. County of Death						
Funeral Director	5. Social Security Number <i>213-30-8933</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>78</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>1-1-1934</i>	9. Birthplace (State or Foreign Country) <i>MD</i>						
	10a. State <i>MD</i>		10b. County		10c. City, Town or Location <i>Baltimore</i>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
To Be Completed by Funeral Director	10e. Street and Number <i>1103 Harlem Avenue</i>			10f. Zip Code <i>21217</i>			10g. Citizen of What Country? <i>USA</i>						
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates. <i>2 years</i>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <i>Black</i>			14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>College (1-4 or 5+)</i> <i>2 years</i>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Computer Operator</i>			16b. Kind of Business/Industry <i>Federal Government</i>						
	17. Father's Name (First, Middle, Last) <i>James Watson</i>			18. Mother's Name (First, Middle, Maiden Surname) <i>Fredericka Watson</i>									
	19a. Informant's Name/Relationship (Type, Print) <i>Leslie Iluyomade (Daughter)</i>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3308 Dorchester Road, Baltimore, MD 21215</i>									
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>Arbutus Memorial</i>			20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Arbutus Memorial</i>			Date <i>3-19-12</i>	20c. Location - City or Town, State <i>Arbutus, MD</i>					
	21. Signature of Funeral Service Licensee <i>Vaughn C. Greene</i>			22. Name and Address of Facility <i>Vaughn C. Greene Funeral Services 5151 Baltimore Nat'l Pike (21229)</i>									
Physician/ Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Cardiovascular Disease</i>								Approximate Interval Between Onset and Death				
	a. Due to (or as a consequence of): <i>Cardiovascular Disease</i>												
	b. Due to (or as a consequence of): <i>Hyperension</i>												
	c. Due to (or as a consequence of): <i>Dabetes</i>												
	d. _____												
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year					
Medical Certificate: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Hyperension Dabetes</i>								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide								28a. Date of injury (Month, Day, Year) <i>March 11, 2012</i>		28b. Time of injury <i>M</i>	28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred <i>From fall</i>
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <i>Merry Medical Center</i>								28f. Location (Street and Number or Rural Route Number, City or Town, State) <i>Baltimore, MD 21215</i>				
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								29d. Date signed (Month, Day, Year) <i>March 11, 2012</i>				
	29b. Signature and title of certifier <i>Karen A. Kozlak, RN, Merry Medical Center</i>								29c. License number <i>840744</i>				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Karen A. Kozlak, RN, Merry Medical Center</i>								31. Date filed (Month, Day, Year) <i>MAR 14 2012</i>				
State Registrar	32. Registrar's Signature <i>Karen A. Kozlak</i>												

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07966

1 - For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Annette Wagner Wilder							2. Date of Death Month Day Year March 07, 2012 148 P M	3. Time of Death	
	4a. Facility Name (If not institution, give street and number) 1005 Stane Rd.			4b. City, Town, or Location of Death Glen Burnie			4c. County of Death Anne Arundel			
Funeral Director	5. Social Security Number 219-01-8272	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 93 Yrs.	If Under 1 Year Months Days Hours Min.	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Feb 25, 1919	9. Birthplace (State or Foreign Country) MD			
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State MD 10b. County Anne Arundel 10c. City, Town or Location Glen Burnie								10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 1005 Stane Rd.			10f. Zip Code 21060			10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Specify: White			14. Race - American Indian, Black, White, etc.		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Home Maker		16b. Kind of Business/Industry Own Home					
	17. Father's Name (First, Middle, Last) Harry M. Wagner				18. Mother's Name (First, Middle, Maiden Surname) Anna Moran					
	19a. Informant's Name/Relationship (Type, Print) Jeanne Osborne Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6025 Snow Crystal, Columbia, MD 21044							
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) K. Gregory Fink MO1148		20b. Place of Disposition (Name of cemetery, crematory or other place) Moreland Memorial Park		Date Mar 12, 2012	20c. Location - City or Town, State Baltimore, MD				
	21. Signature of Funeral Service Licensee K. Gregory Fink		22. Name and Address of Facility Fink Funeral Home, P.A. 426 Crain Hwy S., Glen Burnie, MD 21061							
Physician /Medical Examiner	23a. Part I. Enter the disease(s) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Dementia								Approximate Interval Between Onset and Death	
	23b. If female: 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown <input type="checkbox"/> Unknown								23d. Date of delivery Month Day Year	
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) M		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							
	29b. Signature and title of certifier Monte Wagner, M.D.		29c. License number DS7531			29d. Date signed (Month, Day, Year) March 07, 2012				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Monte Wagner 8601 Veterans Hwy, Millersville, MD 21108									
State Registrar	31. Date filed (Month, Day, Year) MAR 14 2012		32. Registrar's Signature Janice B. Parker							

Baltimore, Maryland 21215-0036

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07967

1 - For
State
Registrar

Physician/
Medical
Examiner

Baltimore, Maryland 21215-0036
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Department of Health and Mental Hygiene.
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Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

State
Registrar

Medical Certificate: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) CLAUDIA A. WARNER		2. Date of Death Month 03 Day 07 Year 12 Time of Death 02:34 AM	
4a. Facility Name (if not institution, give street and number) MERCY MEDICAL CENTER		4b. City, Town, or Location of Death BALTIMORE, MD	
4c. County of Death N/A		3. Time of Death N/A	
5. Social Security Number 212-58-6822		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 59 Yrs.
8. Usual Residence of Decedent N/A		If Under 1 Year Months Days Hours Min.	9. Date of Birth (Month, Day, Year) Feb. 8, 1953
10a. State Maryland		10b. County N/A	10c. City, Town or Location Baltimore
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 2922 Riggs Ave.	
10f. Zip Code 21216		10g. Citizen of What Country? USA	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates. 2	13. Was Decedent of Hispanic Origin? (Specify Yes or No.) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Black
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Administrative Secretary	16b. Kind of Business/Industry State of Maryland
17. Father's Name (First, Middle, Last) Walter Warner Sr.		18. Mother's Name (First, Middle, Maiden Surname) Annabelle Morgan	
19a. Informant's Name/Relationship (Type, Print) Esther Carroll - sister		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 Camano Ct. Randallstown, Maryland 21133	
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) King Mem. Park		20b. Place of Disposition (Name of cemetery, crematory or other place) King Mem. Park	Date 3/17/12
21. Signature of Funeral Service Licensee Kevin Parker		22. Name and Address of Facility Parker Funeral Home P.A. 21229 3512 Frederick Ave. Baltimore, Maryland	
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Lactic Acidosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Metastatic urothelial carcinoma Approximate Interval Between Onset and Death Years			
a. Due to (or as a consequence of): Lactic Acidosis			
b. Due to (or as a consequence of): Metastatic urothelial carcinoma			
c. Due to (or as a consequence of):			
d. Due to (or as a consequence of):			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown	
23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. None			
		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown	
		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year) 1/17/12	28b. Time of injury M
		28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) At home	
		28f. Location (Street and Number or Rural Route Number, City or Town, State) Baltimore, MD 21202	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number P27349	
29b. Signature and title of certifier Physician		29d. Date signed (Month, Day, Year) 03/13/2012	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CARA MORIN, MERCY MEDICAL CENTER, 301 St. Paul Place, Baltimore, MD 21202			
31. Date filed (Month, Day, Year) MAR 14 2012		32. Registrar's Signature Anna J. Gavel	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07968

1 - For
State
Registrar

1. Decedent's Name (First, Middle, Last)

Irene Mae Pattillo Walker

2. Date of Death

Month Day Year

3. Time of Death

6:18 p M

Physician/
Medical
Examiner

4a. Facility Name (if not institution, give street and number)

Doctor's Community Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince George's

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

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Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/
Medical
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

5. Social Security Number

190-28-2271

6. Sex

1 M 2 F

7. Age (In yrs. last birthday)

81

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

07-21-1930

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

MD Prince George's

10b. County

Glenn Dale

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

12221 Guinevere Road

10f. Zip Code

20769

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No)
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) College (1-4 or 5+)

1-4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Nurse

16b. Kind of Business/Industry

PG County Government

17. Father's Name (First, Middle, Last)

Robert Andrew Pattillo

18. Mother's Name (First, Middle, Maiden Surname)

Evelyn Bolyar

19a. Informant's Name/Relationship (Type, Print)

Paul Walker/husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12221 Guinevere Rd., Glenn Dale, MD 20769

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetery

Date

03-16-2012

20c. Location - City or Town, State

Suitland, Maryland

21. Signature of Funeral Service Licensee

Tisha L. Bled

22. Name and Address of Facility

Cedar Hill FH, Inc., 4111 PA Ave., Suitland, MD 20746

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death

a. Due to (or as a consequence of):
Myocardial Infarction

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No

9 Unknown

23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify)
9 Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

End Stage Renal Disease

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

25. Was case referred to medical examiner?

1 Yes 2 No

26. Place of Death (Check only one)

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 5 Pending Investigation
2 Accident 6 Could not be determined
3 Suicide 7 Homicide
4 Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

Stephanie Tritoglio

29c. License number

D 37934

29d. Date signed (Month, Day, Year)

3/11/2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. STEPHANIE TRITOGLIO 1500 Greenway Center Drive, Greenbelt, MD 20770

31. Date filed (Month, Day, Year)

MAR 14 2012

32. Registrar's Signature

Stephanie Tritoglio

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07969

1 - For
State
Registrar

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) WILLIE WEATHERS				2. Date of Death Month 02 Day 29 Year 2012	3. Time of Death 17:52 M
Funeral Director		4a. Facility Name (If not institution, give street and number) St. Agnes Hospital				4b. City, Town, or Location of Death Baltimore	4c. County of Death N/A
To Be Completed by Funeral Director		5. Social Security Number 251-92-1238	6. Sex 1 X M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 61 Yrs.	If Under 1 Year Months Days Hours Min. 	8. Date of Birth (Month, Day, Year) 8-19-1960	9. Birthplace (State or Foreign Country) SOUTH CAROLINA
		Usual Residence of Decedent 10a. State MD. 10b. County N/A				10c. City, Town or Location BALTIMORE	10d. Inside City Limits 1 X Yes 2 <input type="checkbox"/> No
		10e. Street and Number 2801 WINWOOD CT.				10f. Zip Code 21225	10g. Citizen of What Country? USA
		11. Marital Status 1 X Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 X No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 X No Specify:	14. Race - American Indian, Black, White, etc. BLACK		
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) -12-	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) -0-	16b. Kind of Business/Industry LABORER			
		17. Father's Name (First, Middle, Last) LOUIS WEATHERS				18. Mother's Name (First, Middle, Maiden Surname) WILAMAINA WEATHERS	
		19a. Informant's Name/Relationship (Type, Print) LATRINA HALL (NIECE)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2801 WINWOOD CT. BALTIMORE, MARYLAND 21225			
		20a. Method of Disposition 1 X Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) TRINITY CEMETERY	Date 3-13-2012	20c. Location - City or Town, State BALTIMORE, MARYLAND	
		21. Signature of Funeral Service Licensee JONATHAN D. HIBNER		22. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217			
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Septic Shock				Approximate Interval Between Onset and Death 1 Day	
		b. Due to (or as a consequence of): Pneumonia				1 week	
		c. Due to (or as a consequence of): Lung Cancer				3 month	
		d.					
Physician/ Medical Examiner		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year 	
Medical Certificate: To Be Completed by Physician/Medical Examiner		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year) 	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 		28f. Location (Street and Number or Rural Route Number, City or Town, State) 	
		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
		29b. Signature and title of certifier R. MD		29c. License number P 24064		29d. Date signed (Month, Day, Year) 2/29/2012	
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ZAR ZAR PE, 900 Lenton Avenue, Baltimore, MD - 21229					
		31. Date filed (Month, Day, Year) MAR 14 2012		32. Registrar's Signature James J. Farley			

ORIGINAL

Baltimore, Maryland 21215-0036
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

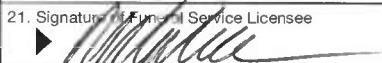
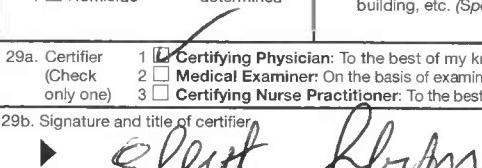
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07970

1 - For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Irene Lucenda Allor					2. Date of Death Month Day Year February 25 2012	3. Time of Death 5:14 P M	
	4a. Facility Name (if not institution, give street and number) Riva Terrace II			4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arundel		
Funeral Director	5. Social Security Number 225-24-5263		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months Days Hours Min. 	8. Date of Birth (Month, Day, Year) 09/30/1923	9. Birthplace (State or Foreign Country) Virginia	
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland	10b. County Anne Arundel	10c. City, Town or Location Edgewater				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 3525 Cedar Drive			10f. Zip Code 21037		10g. Citizen of What Country? United States		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Telephone Operator		16b. Kind of Business/Industry AT&T			
	17. Father's Name (First, Middle, Last) Carl Ferguson				18. Mother's Name (First, Middle, Maiden Surname) Mary Coleman			
	19a. Informant's Name/Relationship (Type, Print) Mary Downs/Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3525 Cedar Drive, Edgewater, Maryland 21037					
Physician/ Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Kalas Crematory		Date 3/2/12	20c. Location - City or Town, State Edgewater, MD		
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, MD 21037					
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	<p>a. <u>Emphysema</u> Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>							
	Approximate Interval Between Onset and Death 5 years							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
	<p>24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>							
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
Medical Certificate: To Be Completed by Physician/Medical Examiner	Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Ajiskell Luv							
	26. Place of Death (Check only one)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier 				29c. License number D20094		29d. Date signed (Month, Day, Year) 02/27/2012	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Elliott Gorbaty, 1411 Madison Park Drive, Suite 2B, Glen Burnie, MD 21061							
	31. Date filed (Month, Day, Year) FEB 28 2012		32. Registrar's Signature 					

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07971

1 - For
State
Registrar

Physician/
Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Monica Bonilla

2. Date of Death
Month Day Year
February 17, 2012

3. Time of Death
9:40 A M

4a. Facility Name (if not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

none

6. Sex
1 M 2 F

7. Age (In yrs. last birthday)
Yrs.

If Under 1 Year
Months Days Hours Min.

1

8. Date of Birth
(Month, Day, Year)
Feb. 16, 2012

9. Birthplace (State or Foreign
Country)
Silver Spring, MD

Usual Residence of Decedent

10a. State

10b. County

Maryland Prince Georges

10c. City, Town or Location

Hyattsville

10d. Inside City Limits
1 Yes 2 No

10e. Street and Number

7008 23rd Avenue

10f. Zip Code

20783

10g. Citizen of What Country?

United States

11. Marital Status

1 Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.
Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No)
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify: **El Salvador**

14. Race - American Indian,
Black, White, etc.

Specify: **Hispanic**

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Seconday (0-12)
0

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Infant

16b. Kind of Business Industry

Never Worked

17. Father's Name (First, Middle, Last)

Vidal Carranza

18. Mother's Name (First, Middle, Maiden Surname)

Carmen Bonilla

19a. Informant's Name/Relationship (Type, Print)

Vidal Carranza, Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7008 23rd Avenue, Hyattsville, Maryland 20783

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of
cemetery, crematory or other place)

Date

20c. Location - City or Town, State

Ft. Lincoln Crematory

2/29/2012

Brentwood, Maryland

21. Signature of Funeral Service Licensee

► *Ann Rowe* MO1102

22. Name and Address of Facility

Simple Tribute

1040 Rockville Pike, Rockville, Maryland 20852

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)

Approximate
Interval Between
Onset and Death
33 hours

Extreme prematurity

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. _____

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?

1 Yes 2 No
9 Unknown

23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (Specify)
9 Unknown

23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

25. Was case referred to medical
examiner?

1 Yes 2 No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

Other:

4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural

5 Pending
Investigation

2 Accident

6 Could not be
determined

3 Suicide

7 Injury at
work?

4 Homicide

M

1 Yes 2 No

28d. Describe how injury occurred

28a. Date of injury
(Month, Day, Year)

28b. Time of
injury

28c. Injury at
work?

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,
City or Town, State)

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

► *Andrea Lotz, M.D.*

29c. License number

D55515

29d. Date signed (Month, Day, Year)

02/17/2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Andrea Lotz, 1500 Forest Glen Road, Silver Spring, Maryland 20910

31. Date filed (Month, Day, Year)

FEB 29 2012

32. Registrar's Signature

Leanne A. Patel

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial ticket.

Medical Certificate: To Be Completed by Physician/Medical Examiner

State
Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07972

1 - For
State
Registrar

**Physician/
Medical
Examiner**

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Alexander Jay Behr AKA Dick A.J. Behr	February 25, 2012	0430 M

4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death
Holy Cross Hospital	Silver Spring

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
383-26-4121	1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	91 Yrs.		April 03, 1920	New York

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Michigan	Wayne	Dearborn	

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
15091 Ford Road, Apt. BP#108	48126	U.S.A.

11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates. WWII	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: White
--	---	---	--

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 3	16b. Kind of Business/Industry Commercial and Residential Real Estate Real Estate Appraiser
---	--	---

17. Father's Name (First, Middle, Last) Herman G. Behr	18. Mother's Name (First, Middle, Maiden Surname) Jennie Pollaschek
---	--

19a. Informant's Name/Relationship (Type, Print) Ginger Behr McLaughlin/Daughter	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7400 Fairfax Road, Bethesda, Maryland 20814
---	--

20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Crematory	Date	20c. Location - City or Town, State Brentwood, Maryland
---	--	------	--

21. Signature of Funeral Service Licensee ►Appellane Warner 1232	22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904
---	---

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Approximate Interval Between Onset and Death
a. Respiratory Failure Due to (or as a consequence of):	
b. Pulmonary Edema Due to (or as a consequence of):	
c. Myocardial Infarction Due to (or as a consequence of):	
d. _____	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
---	---	---

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
--	--

25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
---	---	---	---

27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide	28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	29b. Signature and title of certifier ►H.V. Lawson, M.D.	29c. License number D67589	29d. Date signed (Month, Day, Year) February 27, 2012
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Harold V. Lawson, M.D., 1500 Forest Glen Road, Silver Spring, Maryland 20910	31. Date filed (Month, Day, Year) FEB 29 2012	32. Registrar's Signature Suzanne J. Spaulding
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Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Medical Certificate: To Be Completed by Physician/Medical Examiner

**State
Registrar**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1 - For State Register AMEND#24a/24bperMD, 2/29/12; BMW, Moco Certificate of Death

Reg. No. 2012 07973

Physician/
Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/
Medical
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68700

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial certificate.

State
Registrar

1 - For State Register AMEND#24a/24bperMD, 2/29/12; BMW, Moco Certificate of Death			
1. Decedent's Name (First, Middle, Last) Mildred Arline Bare		2. Date of Death Month February Day 24 Year 2012	
4a. Facility Name (if not institution, give street and number) The Johns Hopkins Hospital		4b. City, Town, or Location of Death Baltimore City	
4c. County of Death		3. Time of Death M	
5. Social Security Number 570-74-3766		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	
7. Age (In yrs. last birthday) 65 Yrs.		If Under 1 Year Months Days Hours Min.	
10a. State MD.		10b. County CALVERT	
10c. City, Town or Location LUSBY		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number 714 LAZY RIVER RD.		10f. Zip Code 20657	
10g. Citizen of What Country? U.S.A.			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	
13. Was Decedent of Hispanic Origin? (Specify Yes or No) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SECRETARY	
16b. Kind of Business/Industry PLAQUE SHACK			
17. Father's Name (First, Middle, Last) CHARLES J. BUDDINGTON		18. Mother's Name (First, Middle, Maiden Surname) MILDRED BOTT	
19a. Informant's Name/Relationship (Type, Print) DALLAS W. BARE/HUSBAND		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 714 LAZY RIVER RD., LUSBY, MD. 20657	
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) CHAMBERS CREMATORY	
		Date 2-25-2012	20c. Location - City or Town, State RIVERDALE, MD.
21. Signature of Funeral Service Licensee W.W. Chambers M00091		22. Name and Address of Facility CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. 5801 CLEVELAND AVE., RIVERDALE, MD. 20737	
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death	
a. Due to (or as a consequence of): SEPSIS			
b. Due to (or as a consequence of):			
c. Due to (or as a consequence of):			
d. Due to (or as a consequence of):			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown	
		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)	28b. Time of injury
		M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier MD	
		29c. License number 12es - 000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Davis Sim		29d. Date signed (Month, Day, Year) February 24, 2012	
31. Date filed (Month, Day, Year) FEB 29 2012		32. Registrar's Signature Leanne B. Farrel	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07974

1- For
State
Registrar

Physician/
Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial certificate.

State
Registrar

1- For State Registrar		1. Decedent's Name (First, Middle, Last) <i>Diana C. Bazata</i>				2. Date of Death Month 02 Day 23 Year 2012			3. Time of Death 2:05PM		
Physician/ Medical Examiner		4a. Facility Name (if not institution, give street and number) <i>Laurel Regional Hospital</i>				4b. City, Town, or Location of Death <i>Laurel</i>			4c. County of Death Prince Georges		
Funeral Director		5. Social Security Number 577-09-6982		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 101 Yrs.	If Under 1 Year Months <input type="checkbox"/> Days <input type="checkbox"/>	If Under 24 Hrs. Hours <input type="checkbox"/> Min. <input type="checkbox"/>	8. Date of Birth Month <input type="checkbox"/> Day <input type="checkbox"/> Year Feb. 12, 1911	9. Birthplace (State or Foreign Country) Italy		
To Be Completed by Funeral Director		Usual Residence of Decedent 10a. State Maryland 10b. County Montgomery 10c. City, Town or Location Bethesda							10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
To Be Completed by Funeral Director		10e. Street and Number 5101 River Road, #1616				10f. Zip Code 20816			10g. Citizen of What Country? United States		
To Be Completed by Funeral Director		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
To Be Completed by Funeral Director		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cosmetologist			16b. Kind of Business Industry Beauty products		
To Be Completed by Funeral Director		17. Father's Name (First, Middle, Last) Giacomo Chirieleison				18. Mother's Name (First, Middle, Maiden Surname) Carmela Brigulio					
To Be Completed by Funeral Director		19a. Informant's Name/Relationship (Type, Print) Don Chirieleison -nephew				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 409 Victoria Court Vienna, Virginia 22180					
To Be Completed by Funeral Director		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery		Date 3.1.2012		20c. Location - City or Town, State Suitland, Maryland			
To Be Completed by Funeral Director		21. Signature of Funeral Service Licensee <i>Donald V. Borgwardt</i>				22. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705					
To Be Completed by Physician/Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)							Approximate Interval Between Onset and Death		
To Be Completed by Physician/Medical Examiner		a. <i>Staph Aureus Septicemia</i> Due to (or as a consequence of):									
To Be Completed by Physician/Medical Examiner		b. Due to (or as a consequence of):									
To Be Completed by Physician/Medical Examiner		c. Due to (or as a consequence of):									
To Be Completed by Physician/Medical Examiner		d. Due to (or as a consequence of):									
To Be Completed by Physician/Medical Examiner		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month <input type="checkbox"/> Day <input type="checkbox"/> Year			
To Be Completed by Physician/Medical Examiner		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Type 2 Diabetes. Dementia. Dehydration failure to thrive</i>				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
To Be Completed by Physician/Medical Examiner						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
To Be Completed by Physician/Medical Examiner		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
To Be Completed by Physician/Medical Examiner		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
To Be Completed by Physician/Medical Examiner		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
To Be Completed by Physician/Medical Examiner		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
To Be Completed by Physician/Medical Examiner		29b. Signature and title of certifier <i>Karunwi ms</i>				29c. License number D 68782			29d. Date signed (Month, Day, Year) 02. 23. 2012		
To Be Completed by Physician/Medical Examiner		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Adeleji Karunwi MD laurel</i>				31. Date filed (Month, Day, Year) FEB 29 2012			32. Registrar's Signature <i>Laura J. Parker</i>		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

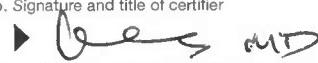
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07975

1 - For
State
RegistrarPhysician/
Medical
Examiner

		1. Decedent's Name (First, Middle, Last) CAROLE M BOYLLS				2. Date of Death Month Day Year FEBRUARY 23 2012	3. Time of Death 2:55 PM		
		4a. Facility Name (if not institution, give street and number) FREDERICK MEMORIAL HOSPITAL		4b. City, Town, or Location of Death FREDERICK		4c. County of Death FREDERICK			
Funeral Director		5. Social Security Number 317-34-7303	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) 76 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Aug. 23, 1935	9. Birthplace (State or Foreign Country) Indiana		
To Be Completed by Funeral Director		Usual Residence of Decedent 10a. State Maryland				10b. County Frederick			
		10c. City, Town or Location Frederick		10f. Zip Code 21701		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
		10e. Street and Number 9032 Spring Valley Drive		10g. Citizen of What Country? United States					
		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: White				
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Secretary	16b. Kind of Business Industry State Government					
		17. Father's Name (First, Middle, Last) Herman C. Hayes		18. Mother's Name (First, Middle, Maiden Surname) Madelyn Hart					
		19a. Informant's Name/Relationship (Type, Print) Robert Boylls / Husband		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9032 Spring Valley Drive Frederick, Maryland 21701					
		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) Stauffer Crematory		20b. Place of Disposition (Name of cemetery, crematory or other place) Stauffer Crematory	Date February 27, 2012	20c. Location - City or Town, State Frederick, Maryland			
		21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Stauffer Funeral Homes, P.A.		23. Approximate Interval Between Onset and Death			
				1621 Opossumtown Pike Frederick, Maryland 21702					
Physician/ Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cancer						Approximate Interval Between Onset and Death	
		a. Due to (or as a consequence of): Cancer							
		b. Due to (or as a consequence of):							
		c. Due to (or as a consequence of):							
		d. _____							
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year			
Medical Certificate: To Be Completed by Physician/Medical Examiner		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred		
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
		29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
		29b. Signature and title of certifier 		29c. License number D60917		29d. Date signed (Month, Day, Year) 2-24-2012			
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Heman Shah MD, 65c Thomas Johnson Dr, Frederick MD 21702							
State Registrar		31. Date filed (Month, Day, Year) FEB 28 2012		32. Registrar's Signature 					

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07976

1- For
State
RegistrarPhysician/
Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

		1. Decedent's Name (First, Middle, Last)			2. Date of Death		3. Time of Death	
		Robert Henry Bruette			Month Day Year February 25, 2012		11:15 AM	
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death			4c. County of Death			
206 Calvert Street		Lusby			Calvert			
5. Social Security Number		6. Sex	7. Age (in yrs. last birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of Birth	9. Birthplace (State or Foreign Country)	
262-27-5026		1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	55 Yrs.	Months	Days	Month Day Year 10/08/1956	Florida	
Usual Residence of Decedent		10c. City, Town or Location			10d. Inside City Limits			
10a. State		10b. County			10d. Inside City Limits			
Maryland		Calvert			Lusby			
10e. Street and Number		10f. Zip Code			10g. Citizen of What Country?			
206 Calvert Street		20657			United States			
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)		14. Race - American Indian, Black, White, etc.		
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates. 1975-1996		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		Specify: White		
15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business Industry			
Elementary/Secondary (0-12)		College (1-4 or 5+) 4			Computer Logistics US Government			
17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)						
Duane M. Bruette		Marian Knox						
19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)						
Theresa H. Bruette / Wife		206 Calvert Drive, Lusby, MD 20657						
20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date		20c. Location - City or Town, State		
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		Metropolitan Crematory		02/27/2012		Arlington, Virginia		
21. Signature of Funeral Service Licensee		22. Name and Address of Facility			Rausch Funeral Home, P.A. P.O. Box 600, Lusby, MD 20657			
<i>Michael Kevin Hardner</i>								
23a. Part 1. Enter the disease(s) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Metastatic pancreatic cancer			Approximate Interval Between Onset and Death 2 months			
a. Due to (or as a consequence of):								
b. Due to (or as a consequence of):								
c. Due to (or as a consequence of):								
d. Due to (or as a consequence of):								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <i>CKL</i>		29c. License number D56024			29d. Date signed (Month, Day, Year) February 27, 2012			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)								
Kenneth L. Abbott, MD 110 Hospital Road, Suite 110, Prince Frederick, MD 20678								
31. Date filed (Month, Day, Year) FEB 28 2012		32. Registrar's Signature <i>James A. Spangler</i>						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend item 5 per th g925 3-14-12 vt

State of Maryland / Department of Health and Mental Hygiene

1 - For
State
Registrar

Certificate of Death

Reg. No.

2012 07977

**Physician/
Medical
Examiner**

**Funeral
Director**

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) Ladoris K. Bryant				2. Date of Death Month 02 /Day 21 /Year 2012	3. Time of Death 20:48 P M
4a. Facility Name (if not institution, give street and number) Prince Georges Hospital Center				4b. City, Town, or Location of Death Cheverly	
5. Social Security Number 579-56-2990-2590		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 67 Yrs.	If Under 1 Year Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min.	8. Date of Birth (Month Day Year) 10/13/1944
9. Birthplace (State or Foreign Country) Maryland					
Usual Residence of Decedent					
10a. State Maryland	10b. County Prince Georges	10c. City, Town or Location Landover			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number 8614 Girard Street			10f. Zip Code 20785		10g. Citizen of What Country? USA
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Social Work		16b. Kind of Business Industry Prince Georges Co. Government	
17. Father's Name (First, Middle, Last) Ulysses West				18. Mother's Name (First, Middle, Maiden Surname) Christine Russell	
19a. Informant's Name/Relationship (Type, Print) Edward Bryant (Husband)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8614 Girard St. Landover, MD 20785		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Washington Nat. Cem.		Date 03/03/2012	20c. Location - City or Town, State Suitland, Maryland
21. Signature of Funeral Service Licensee Laborie Bryant		22. Name and Address of Facility Rendon/Hale Funeral Home 9013 Annapolis Rd. Lanham, MD 20706			

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)						Approximate Interval Between Onset and Death Weeks
a. Sepsis Due to (or as a consequence of):						
b. Aspiration Pneumonia Due to (or as a consequence of):						Weeks
c. Infected Decubitus Ulcer Due to (or as a consequence of):						Weeks
d. _____						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Metastatic Lung Cancer						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
CVA						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Anemia						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
29b. Signature and title of certifier Davey Ibitoye MD				29c. License number D0051437		29d. Date signed (Month, Day, Year) 02/23/2012
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Okeowo D. Ibitoye 12200 Annapolis Rd. #232 Glenn Dale, MD 20769						
31. Date filed (Month, Day, Year) FEB 29 2012		32. Registrar's Signature Janice S. Gates				

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07978

1 - For
State
Registrar

Physician/
Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician/
Medical
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death 8:57 P M
James Shakespeare Bowling, Jr.			March 6, 2012	
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
St. Mary's Hospice House		Callaway		St. Mary's
5. Social Security Number 217-36-7063	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 73 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 11/17/1938
Usual Residence of Decedent Maryland Charles		9. Birthplace (State or Foreign Country) Maryland		
10a. State Maryland	10b. County Charles	10c. City, Town or Location Charlotte Hall	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 10460 Old Sycamore Road		10f. Zip Code 20622	10g. Citizen of What Country? U S	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)	16b. Kind of Business/Industry Farmer Agriculture		
17. Father's Name (First, Middle, Last) James Shakespeare Bowling			18. Mother's Name (First, Middle, Maiden Surname) Margaret Marie Herbert	
19a. Informant's Name/Relationship (Type, Print) Catherine T. Bowling/Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10460 Old Sycamore Rd., Charlotte Hall, MD 20622		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) St. Mary's Cemetery	Date 03/12/2012	20c. Location - City or Town, State Newport, Maryland
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Brinsfield-Echols F.H., P.A. 30195 Three Notch Rd., Charlotte Hall, MD 20622		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
<p>a. Due to (or as a consequence of): <i>End Stage Renal Disease</i></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>				
Approximate Interval Between Onset and Death				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		
		23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <i>Hospice House</i>		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No
		28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. Signature and title of certifier 		29c. License number H0055751	29d. Date signed (Month, Day, Year) 3-7-12	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Jennifer Schmidt DO 40900 Merchants Lane Suite 205 Leonardtown MD 20650</i>				
31. Date filed (Month, Day, Year) MAR 14 2012		32. Registrar's Signature 		

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07979

1- For
State
Registrar

**Physician/
Medical
Examiner**

1. Decedent's Name (First, Middle, Last) Evelyn H. Beasley		2. Date of Death Month March Day 1 Year 2012		3. Time of Death 12:35P.M.
4a. Facility Name (if not institution, give street and number) Holy Cross Hospital		4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery
5. Social Security Number 578-36-2048		6. Sex M	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days Hours Min.
Usual Residence of Decedent Maryland		10a. State Maryland		10b. County Prince George's
		10c. City, Town or Location Silver Spring		10d. Inside City Limits Yes
10e. Street and Number 3142 Gracefield Road, #MG503		10f. Zip Code 20904		10g. Citizen of What Country? United States
11. Marital Status Never Married		12. Was Decedent Ever in U.S. Armed Forces? No		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. No
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry own home
17. Father's Name (First, Middle, Last) Charles Harbough		18. Mother's Name (First, Middle, Maiden Surname) Melba Jones		
19a. Informant's Name/Relationship (Type, Print) Rogers F. Beasley -husband		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3142 Gracefield Rd., #MG503 Silver Spring, MD 20904		
20a. Method of Disposition Burial		20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cem.		Date 3/5/2012
20c. Location - City or Town, State Silver Spring, MD				
21. Signature of Funeral Service Licensee Donald V. Borgwardt		22. Name and Address of Facility Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705		
23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death
a. Acute Renal Failure Due to (or as a consequence of):				
b. Diabetes Due to (or as a consequence of):				
c. Due to (or as a consequence of):				
d. _____				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Sleep Apnea; Hypertension		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year) M	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number D68681		29d. Date signed (Month, Day, Year) March 2, 2012
29b. Signature and title of certifier Charu Maheshwary, M.D.		29c. License number D68681		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charu Maheshwary, M.D. HCH 1500 Forest Glen Road Silver Spring, Maryland 20910				
31. Date filed (Month, Day, Year) MAR 14 2012		32. Registrar's Signature Debra J. Parker		

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10
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**State
Registrar**

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07980

1 - For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) JAMES CONNORS					2. Date of Death Month FEB Day 20 Year 2012	3. Time of Death 4:10 AM			
	4a. Facility Name (if not institution, give street and number) WRNMMC					4b. City, Town, or Location of Death BETHESDA		4c. County of Death MONTGOMERY		
Funeral Director	5. Social Security Number 165-20-8571		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months 83	If Under 24 Hrs. Days 0	8. Date of Birth (Month, Day, Year) Sept. 6, 1928	9. Birthplace (State or Foreign Country) Pennsylvania		
	Usual Residence of Decedent Maryland		10a. State Maryland		10b. County Montgomery			10c. City, Town or Location Gaithersburg		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
To Be Completed by Funeral Director	10e. Street and Number 891 Clopper Road, Apt. A3				10f. Zip Code 20878			10g. Citizen of What Country? United States		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates. 1946-1965		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. Specify: White
Physician/ Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Electrical Engineer			16b. Kind of Business Industry Engineering		
	17. Father's Name (First, Middle, Last) Timothy Connors				18. Mother's Name (First, Middle, Maiden Surname) Mary Horton					
Medical Certificate: To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Della Mae Connors (Spouse)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 891 Clopper Road, Apt. A3, Gaithersburg, MD 20878					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington National Cemetery		Date March 7, 2012	20c. Location - City or Town, State Arlington, Virginia		
Medical Certificate: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee [Signature]				22. Name and Address of Facility DeVol Funeral Home, 10 E. Deer Park Drive, Gaithersburg, MD 20877					
	23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)				23b. Due to (or as a consequence of): METASTATIC BLADDER CANCER			Approximate Interval Between Onset and Death		
Medical Certificate: To Be Completed by Physician/Medical Examiner	23c. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				23d. Due to (or as a consequence of):					
					23e. Due to (or as a consequence of):					
Medical Certificate: To Be Completed by Physician/Medical Examiner	23f. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown				23g. 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			23f. 23g.		
Medical Certificate: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			23h. 23i.		
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined				28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred	
Medical Certificate: To Be Completed by Physician/Medical Examiner	29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier [Signature]			29c. License number VA 0101044261		
								29d. Date signed (Month, Day, Year) February 23, 2012		
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GLENN W. WORTMANN, MD				31. Date filed (Month, Day, Year) FEB 28 2012			32. Registrar's Signature [Signature]		
	33. WRNMMC, BETHESDA, MD 20889									

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial transit slip.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07981

1- For State Registrar		1. Decedent's Name (First, Middle, Last) Charles Cappaninee 2. Date of Death Month February Day 27 , 2012 Year 3. Time of Death 2:57 A M									
Physician/ Medical Examiner		4a. Facility Name (if not institution, give street and number) Washington Adventist Hospital 4b. City, Town, or Location of Death Takoma Park 4c. County of Death Montgomery									
Funeral Director		5. Social Security Number 579-58-2793		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F 7. Age (In yrs. last birthday) 72		If Under 1 Year Months 72		If Under 24 Hrs. Days 0		8. Date of Birth Month, Day, Year March 8, 1939	
To Be Completed by Funeral Director		9. Birthplace (State or Foreign Country) DC									
To Be Completed by Physician/Medical Examiner		10a. State Virginia		10b. County Stafford		10c. City, Town or Location Stafford		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
Medical Certificate: To Be Completed by Physician/Medical Examiner		10e. Street and Number 101 Oak Drive		10f. Zip Code 22554		10g. Citizen of What Country? United States					
To Be Completed by Physician/Medical Examiner		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates. unk.		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: African/Italian		14. Race - American Indian, Black, White, etc. Specify: African/Italian			
To Be Completed by Physician/Medical Examiner		15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Installer		16b. Kind of Business Industry Self-Employed					
To Be Completed by Physician/Medical Examiner		17. Father's Name (First, Middle, Last) Nicholas Williams		18. Mother's Name (First, Middle, Maiden Surname) Florita unk.							
To Be Completed by Physician/Medical Examiner		19a. Informant's Name/Relationship (Type, Print) Ernestine V. Cappaninee/Spouse		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 101 Oak Drive Stafford, Virginia 22554							
To Be Completed by Physician/Medical Examiner		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) M00560		20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill		20c. Date - City or Town, State March 2, 2012 Suitland, Maryland					
To Be Completed by Physician/Medical Examiner		21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road NE Washington, DC 20019							
To Be Completed by Physician/Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Atherosclerotic Cardiovascular disease Approximate Interval Between Onset and Death									
To Be Completed by Physician/Medical Examiner		a. Due to (or as a consequence of): Sepsis									
To Be Completed by Physician/Medical Examiner		b. Due to (or as a consequence of): 									
To Be Completed by Physician/Medical Examiner		c. Due to (or as a consequence of): 									
To Be Completed by Physician/Medical Examiner		d. Due to (or as a consequence of): 									
To Be Completed by Physician/Medical Examiner		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year					
To Be Completed by Physician/Medical Examiner		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
To Be Completed by Physician/Medical Examiner		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
To Be Completed by Physician/Medical Examiner		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year) 28b. Time of injury M		28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred 			
To Be Completed by Physician/Medical Examiner		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
To Be Completed by Physician/Medical Examiner		29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number D0060100		29d. Date signed (Month, Day, Year) 02-27-12			
To Be Completed by Physician/Medical Examiner		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 831 University Blvd., Apt 12, Takoma Park, MD 20903									
To Be Completed by Physician/Medical Examiner		31. Date filed (Month, Day, Year) FEB 28 2012		32. Registrar's Signature 							

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07982

1 - For
State
RegistrarPhysician/
Medical
Examiner

		1. Decedent's Name (First, Middle, Last) Virginia R. Churn						2. Date of Death Month 03 Day 05 Year 2012		3. Time of Death 11:13 A M	
		4a. Facility Name (if not institution, give street and number) 2711 Lawndale Road						4b. City, Town, or Location of Death Finksburg		4c. County of Death Carroll	
Funeral Director		5. Social Security Number 217-01-6213	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 95 Yrs.	If Under 1 Year Months 	If Under 24 Hrs. Hours 	8. Date of Birth (Month, Day, Year) 08/26/1916	9. Birthplace (State or Foreign Country) MD			
To Be Completed by Funeral Director		10a. State MD		10b. County Carroll		10c. City, Town or Location Finksburg			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
		10e. Street and Number 2711 Lawndale Road			10f. Zip Code 21048			10g. Citizen of What Country? USA			
		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 2 medical secretary		16b. Kind of Business/Industry Dr. Martin Strobel					
		17. Father's Name (First, Middle, Last) Howard Robinson			18. Mother's Name (First, Middle, Maiden Surname) Carrie Ogelsby						
		19a. Informant's Name/Relationship (Type, Print) Robin Bitner/daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2711 Lawndale Road, Finksburg, MD 21048						
		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Druid Ridge Cemetery		Date 03/09/2012	20c. Location - City or Town, State Baltimore, MD				
		21. Signature of Funeral Service Licensee J. K. Strobel		22. Name and Address of Facility Pitts Funeral Home and Chapel, P.A. 412 Washington Road, Westminster, MD 21157							
Physician/ Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CARDIASCUR						Approximate Interval Between Onset and Death 4 years			
		b. CARDIOMEGALY Due to (or as a consequence of): c. Chronic AFIBRILLATION. Due to (or as a consequence of): d. 									
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year				
Medical Certificate: To Be Completed by Physician/Medical Examiner		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Esophageal Spasm. Dependent Edema.						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			23f. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year) 	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred 				
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 			28f. Location (Street and Number or Rural Route Number, City or Town, State) 				
		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number D37949			29d. Date signed (Month, Day, Year) 3-6-2012				
		30. Name and address of person in who completed cause of death (Item 23a) (Type, Print) Alexander Boggschreuder, no 2 West Ave, Suite #201, Westminster									
		31. Date filed (Month, Day, Year) MAR 14 2012		32. Registrar's Signature J. Strobel							

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07983

1 - For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Janice Violette Crowley						2. Date of Death Month 03	Day 07	Year 2012	3. Time of Death 3:56 P M
	4a. Facility Name (if not institution, give street and number) Hospice House			4b. City, Town, or Location of Death Callaway			4c. County of Death St. Mary's			
Funeral Director	5. Social Security Number 024-28-0821	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) Yrs. 75	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) 12/13/1936	9. Birthplace (State or Foreign Country) MA			
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State Maryland 10b. County St. Mary's 10c. City, Town or Location Callaway 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
	10e. Street and Number 44724 Hospice Lane			10f. Zip Code 20620			10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 2	14. Race - American Indian, Black, White, etc. Specify: White						
	17. Father's Name (First, Middle, Last) David Violette	18. Mother's Name (First, Middle, Maiden Surname) Frances Goodridge Violette	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker	16b. Kind of Business Industry Home						
	19a. Informant's Name/Relationship (Type, Print) John Cornelius Crowley/Husband	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19308 Gosnell Road Leonardtown, MD 20650	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) Brinsfield-Echols Cre	20b. Place of Disposition (Name of cemetery, crematory or other place) Brinsfield-Echols Cre	Date 3/9/2012	20c. Location - City or Town, State Charlotte Hall, MD				
	21. Signature of Funeral Service Licensee Hayton C. Delaney III	22. Name and Address of Facility Brinsfield-Echols Funeral Home, P.A. 30195 Three Notch Road Charlotte Hall, MD 20622	23a. Part 1. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death			
Physician/ Medical Examiner	a. Due to (or as a consequence of): Congestive Heart Failure	b. Due to (or as a consequence of): Coronary Artery Disease	c. Due to (or as a consequence of):	d. Due to (or as a consequence of):						
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year							
Medical Certificate: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice House			24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide	28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred Hospice House					
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	29b. Signature and title of certifier Jennifer Schmidt, M.D.	29c. License number M0055751			29d. Date signed (Month, Day, Year) 03-07-2012					
State Registrar	31. Date filed (Month, Day, Year) MAR 14 2012	32. Registrar's Signature Suzanne J. Parker								

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

10 gm

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND#17perFH, 2/29/12; BMW, MOO Certificate of Death

Reg. No. 2012 07984

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Savva Dubinsky				2. Date of Death Month Day Year February 20, 2012	3. Time of Death 7:15 A M	
	4a. Facility Name (if not institution, give street and number) 5801 Nicholson Lane #511		4b. City, Town, or Location of Death Rockville	4c. County of Death Montgomery			
Funeral Director	5. Social Security Number 062-60-7365	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) February 28, 1928	9. Birthplace (State or Foreign Country) Kiev, Ukraine	
	Usual Residence of Decedent Maryland Montgomery		10c. City, Town or Location Rockville		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number 5801 Nicholson Lane #511			10f. Zip Code 20852	10g. Citizen of What Country? United States		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No.) If Yes, specify Cuban, Mexican, Puerto Rican, etc. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: Caucasian			
	15. Decedent's Education (Specify only highest grade completed) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Jeweler	16b. Kind of Business/Industry Jewelry			
	17. Father's Name (First, Middle, Last) Naum Dubinsky Spouse			18. Mother's Name (First, Middle, Maiden Surname) Anna Schwartzzer			
	19a. Informant's Name/Relationship (Type, Print) Maya Dubinsky, Spouse		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5801 Nicholson Lane #511, Rockville, Maryland 20852				
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Fort Lincoln Crematory		20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Crematory	Date 2/24/2012	20c. Location - City or Town, State Brentwood, Maryland		
	21. Signature of Funeral Service Licensee Ann Rowe		22. Name and Address of Facility Simple Tribute	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Chronic Obstructive Pulmonary Disease			
				Approximate Interval Between Onset and Death			
			a. Due to (or as a consequence of): Chronic Obstructive Pulmonary Disease				
			b. Due to (or as a consequence of):				
			c. Due to (or as a consequence of):				
			d. Due to (or as a consequence of):				
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Carcinoma of the Sigmoid Colon		23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
			27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide	28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Robert H. Gerard MD				
			29c. License number D0055522				
			29d. Date signed (Month, Day, Year) February 22, 2012				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert H. Gerard, 1500 Forest Glen Road, Silver Spring, Maryland 20910		31. Date filed (Month, Day, Year) FEB 29 2012				
			32. Registrar's Signature Robert H. Gerard				

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial permit.

Medical Certificate: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

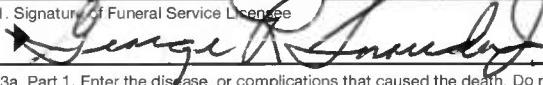
Reg. No.

2012 07985

1 - For
State
Registrar

Physician/
Medical
Examiner

Baltimore, Maryland 21215-0036
To Be Completed by Funeral Director
Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death 3:30 A M	
RONALD WALTER DAVIS		02/25/2012			
4a. Facility Name (if not institution, give street and number) Genesis Healthcare Shady Grove		4b. City, Town, or Location of Death Rockville		4c. County of Death Montgomery	
5. Social Security Number 218-36-2600		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F 7. Age (In yrs. last birthday) 73 Yrs.		If Under 1 Year Months Days Hours Min. 8. Date of Birth (Month Day Year) 08/28/1938	
10a. State MD		10b. County Montgomery		10c. City, Town or Location Rockville	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number 327 Lincoln Avenue		10f. Zip Code 20850		10g. Citizen of What Country? USA	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Landscaping		16b. Kind of Business Industry Lawn	
17. Father's Name (First, Middle, Last) Arthur Davis		18. Mother's Name (First, Middle, Maiden Surname) Katherine A. Walters			
19a. Informant's Name/Relationship (Type, Print) Ruth A. Brown/sister		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 327 Lincoln Avenue, Rockville, MD 20850			
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) Ardent Cremation Svc		20b. Place of Disposition (Name of cemetery, crematory or other place) Ardent Cremation Svc		Date 03/02/2012	20c. Location - City or Town, State Hanover, MD
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St., Rockville, MD 20850			

Division of Vital Records, P.O. Box 68760

To the Physician or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	Approximate Interval Between Onset and Death
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number 00068090		29d. Date signed (Month, Day, Year) 2/28/12			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Summit Gupta, M.D. 9701 Medical Center Drive; Rockville, MD 20850							
31. Date filed (Month, Day, Year) FEB 29 2012		32. Registrar's Signature 					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07986

1 - For
State
Registrar

Physician/
Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Edward Lawrence Davis

2. Date of Death

Month Feb. Day 27, Year 2012

3. Time of Death

4:05 P.M.

4a. Facility Name (if not institution, give street and number)

Manor Care Potomac

4b. City, Town, or Location of Death

Potomac

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

180-18-9213

6. Sex

M

F

7. Age (In yrs. last birthday)

91

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Feb. 11, 1921

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

D.C.

10b. County

None

10c. City, Town or Location

Washington, D.C.

10d. Inside City Limits

Yes 2 No

10e. Street and Number

2237 48th Street N.W.

10f. Zip Code

20007

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 1942-
If Yes, Give Year or Dates. 1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Seconday (0-12) College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Intelligence Analyst

16b. Kind of Business Industry

U.S. Dept. of State

17. Father's Name (First, Middle, Last)

Edward Lawrence Davis

18. Mother's Name (First, Middle, Maiden Surname)

Florence Judge

19a. Informant's Name/Relationship (Type, Print)

Juliet G. Davis/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2237 48th Street N.W.
Washington, D.C. 20007

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory

Date

Feb. 28, 2012

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

► Henry J. Fend

M00215

22. Name and Address of Facility

DeVol Funeral Home

2222 Wisconsin Ave. N.W. Washington, D.C. 20007

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death

a. Debility

Due to (or as a consequence of):

b. Cachexia

Due to (or as a consequence of):

c. Failure To Thrive

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No
9 Unknown

23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify)
9 Unknown

23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?
1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 5 Pending Investigation
2 Accident 6 Could not be determined
3 Suicide
4 Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work?

M 1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
(Check only one)
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

► Loreto Albiol, M.D.

D31319

29c. License number

February 28, 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Loreto Albiol, M.D. 8218 Wisconsin Ave. #305, Bethesda, Md. 20814

31. Date filed (Month, Day, Year)

FEB 29 2012

32. Registrar's Signature

Janice A. Parker

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07987

1- For
State
Registrar

Physician/
Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/
Medical
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

1. Decedent's Name (First, Middle, Last) Daniel J. Estrada			2. Date of Death Month February Day 27 , Year 2012	3. Time of Death 1:55 A M
4a. Facility Name (if not institution, give street and number) Somerford			4b. City, Town, or Location of Death Frederick	
5. Social Security Number 214-42-3060 Usual Residence of Decedent			6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 68 Yrs.
If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) Feb. 10, 1944	9. Birthplace (State or Foreign Country) West Virginia	
10a. State Maryland	10b. County Anne Arundel	10c. City, Town or Location Severna Park		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
10e. Street and Number 44 Marnel Court			10f. Zip Code 21146	10g. Citizen of What Country? USA
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Carpenter		16b. Kind of Business/Industry Carpentry
17. Father's Name (First, Middle, Last) John F. Estrada			18. Mother's Name (First, Middle, Maiden Surname) Anna Lee Gunther	
19a. Informant's Name/Relationship (Type, Print) Tina Tchou / Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4103 Lomar Terrace, Mt. Airy, MD 21771		
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) Stauffer Crematory		Date 2/29/2012	20c. Location - City or Town, State Frederick, Maryland
21. Signature of Funeral Service Licensee <i>John F. Stauffer</i>		22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, MD 21702		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)				
Approximate Interval Between Onset and Death				
a. Due to (or as a consequence of): Dementia				
b. Due to (or as a consequence of):				
c. Due to (or as a consequence of):				
d. Due to (or as a consequence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. Signature and title of certifier 		29c. License number D 51643		29d. Date signed (Month, Day, Year) 2/27/12
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hirsh Shah 65c Thomas Johnson Dr # 2102				
31. Date filed (Month, Day, Year) FEB 28 2012		32. Registrar's Signature Debra S. Parker		

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2012 07988

Certificate of Death

Reg. No.

1 - For
State
Registrar

Physician/
Medical
Examiner

Baltimore, Maryland 21215-0036
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
certificate.

Division of Vital Records, P.O. Box 68760

Medical Certificate: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

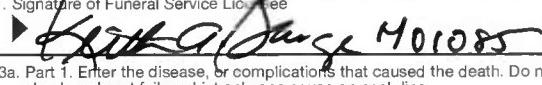
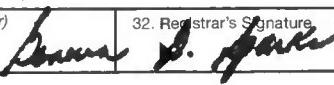
Medical Certificate: To Be Completed by Physician/Medical Examiner

State of Maryland / Department of Health and Mental Hygiene

2012 07988

Certificate of Death

Reg. No.

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death 1300 P M	
Ethel Mae Eldridge		2/ 22/ 2012					
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death				4c. County of Death	
Holy Cross Hospital		Silver Spring				Montgomery	
5. Social Security Number 578-38-2175		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 89 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) 09-15-1922	9. Birthplace (State or Foreign Country) NC
Usual Residence of Decedent MD PG		10c. City, Town or Location Hyattsville				10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number 1382 Chillum Road		10f. Zip Code 20782				10g. Citizen of What Country? US	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Housekeeper		16b. Kind of Business/Industry Private			
17. Father's Name (First, Middle, Last) Willie Swinson		18. Mother's Name (First, Middle, Maiden Surname) Lonnie Whitney					
19a. Informant's Name/Relationship (Type, Print) Etheleen Johnson/Daughter Kirby Eldridge/Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 246 Ricahelitu Terrace, Newark, NJ 07106 7714 Normandy Road, Hyattsville, MD 20785					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Cemetery		Date 3-3-2012	20c. Location - City or Town, State Brentwood, MD		
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Pope Funeral Homes, P.A. 5538 Marlboro Pike, Forestville, MD 20747					
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Aspiration Pneumonia				Approximate Interval Between Onset and Death	
a. Due to (or as a consequence of):							
b. Due to (or as a consequence of):							
c. Due to (or as a consequence of):							
d. _____							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
24. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		25. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> D.O.A Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number D66249				29d. Date signed (Month, Day, Year) 2-22-12	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jonathan Duran, M.D. 1500 Forest Glen Road, Silver Spring, MD 20910							
31. Date filed (Month, Day, Year) FEB 29 2012		32. Registrar's Signature 					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07989

1- For
State
RegistrarPhysician/
Medical
Examiner

		1. Decedent's Name (First, Middle, Last) MARY ELIZABETH FLOOR				2. Date of Death Month March Day 8 , Year 2012	3. Time of Death 4:00 AM		
		4a. Facility Name (if not institution, give street and number) FREDERICK MEMORIAL HOSPITAL				4b. City, Town, or Location of Death FREDERICK	4c. County of Death FREDERICK		
Funeral Director		5. Social Security Number 216-74-3374	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) Feb 25 1926	9. Birthplace (State or Foreign Country) Maryland	
To Be Completed by Funeral Director		Usual Residence of Decedent				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
		10a. State Maryland	10b. County Frederick	10c. City, Town or Location Myersville					
		10e. Street and Number 2744 Canada Hill Road				10f. Zip Code 21773	10g. Citizen of What Country? USA		
		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business Industry Own Home		
		17. Father's Name (First, Middle, Last) Ray Adolph Schroyer				18. Mother's Name (First, Middle, Maiden Surname) Cora Catherine Flook			
		19a. Informant's Name/Relationship (Type, Print) Deanna Flook/daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11303B Woodland Way, Myersville, Maryland 21773			
		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt Zion U Methodist		Date Mar 12 2012	20c. Location - City or Town, State Myersville, Maryland		
		21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Ricketts Funeral Home 504 Main Street Myersville, MD 21773			
		<p>22a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.</p> <p>Immediate Cause (Final disease or condition resulting in death) ACUTE RENAL FAILURE</p> <p>Approximate Interval Between Onset and Death</p> <p>Sequently list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> <p>a. Due to (or as a consequence of): CHRONIC KIDNEY DISEASE</p> <p>b. Due to (or as a consequence of): HYPERTENSION</p> <p>c. Due to (or as a consequence of):</p> <p>d. _____</p>							
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		26. Place of Death (Check only one)	
		27. Manner of Death Natural <input type="checkbox"/> Accident <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
		29b. Signature and title of Certifier 		29c. License number D0061410			29d. Date signed (Month, Day, Year) MARCH, 08, 2012		
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GAFFAR SYED 801 TOLL HOUSE, FREDERICK, MD							
		31. Date filed (Month, Day, Year) MAR 14 2012		32. Registrar's Signature 					

Baltimore, Maryland 21215-0036

To the Physician or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 24a per med cert G925 3/27/12 dk

State of Maryland / Department of Health and Mental Hygiene

1 - For State Registrar AMEND#160perFH, 2/29/12; BM, MoCo

Certificate of Death

Reg. No. 2012 07990

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Walter Lee Freeman				2. Date of Death Month Feb. Day 24 Year 2012		3. Time of Death 1930 M	
	4a. Facility Name (if not institution, give street and number) Prince Georges Hospital		4b. City, Town, or Location of Death Cheverly			4c. County of Death Prince Georges		
Funeral Director	5. Social Security Number 214-12-5125	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 89 Yrs.	If Under 1 Year Months 0 Days 0	If Under 24 Hrs. Hours 0 Min. 0	8. Date of Birth (Month, Day, Year) March 24, 1922	9. Birthplace (State or Foreign Country)	
Usual Residence of Decedent 10a. State Maryland 10b. County Prince Georges 10c. City, Town or Location Glenarden 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
To Be Completed by Funeral Director	10e. Street and Number 7908 Echols Avenue			10f. Zip Code 20706		10g. Citizen of What Country? United States		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Dairyman			16b. Kind of Business Industry Private		
	17. Father's Name (First, Middle, Last) (Unavailable)				18. Mother's Name (First, Middle, Maiden Surname) Fannie Freeman			
	19a. Informant's Name/Relationship (Type, Print) Ethel Cluff (daughter)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7908 Echols Ave, Glenarden, MD 20706					
Physician/ Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Chesapeake		20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake		Date 2-29-12	20c. Location - City or Town, State Bethesda, MD		
Medical Certificate: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Fannie Cluff							
	22. Name and Address of Facility 6503 Old Brandy Ave, 20748 JK Johnson Funeral Home Temple Hills, MD							
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Acute Myocardial infarction Approximate Interval Between Onset and Death minutes							
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Diffuse coronary arteriosclerosis years							
	a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Severe Chronic Obstructive lung disease, gross hematuria, Transitional bladder cancer, hypercalcemia							
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No							
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
Medical Certificate: To Be Completed by Physician/Medical Examiner	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death Natural 5 <input type="checkbox"/> Pending Investigation Accident 6 <input type="checkbox"/> Could not be determined Suicide Homicide 28a. Date of injury (Month, Day, Year) 28b. Time of injury M 28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how injury occurred							
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier R Ravinder M.D. 29c. License number D24720 29d. Date signed (Month, Day, Year) 2/25/12							
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cheverly MD 20785 6132 Landover Road Ravinder K. Rustagi, M.D.							
State Registrar	31. Date filed (Month, Day, Year) FEB 29 2012	32. Registrar's Signature Ravinder K. Rustagi						

Baltimore, Maryland 21215-0036

Permit: Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

(3) To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial permit.

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1 - For State Registry AMEND#20bperFH, 3/5/12, BMW, MCo

Certificate of Death

Reg. No. 2012 07991

Physician/
Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

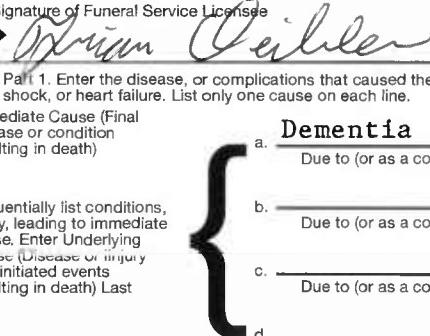
Permit Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial record.

Medical Certificate: To Be Completed by Physician/Medical Examiner

Physician/
Medical
Examiner

1. Decedent's Name (First, Middle, Last) Janet Elaine Fones		2. Date of Death Month February Day 27, 2012		3. Time of Death 4:18 P M
4a. Facility Name (if not institution, give street and number) Wilson Health Care at Asbury Village		4b. City, Town, or Location of Death Gaithersburg		4c. County of Death Montgomery
5. Social Security Number 080-16-7360		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 89 Yrs.	If Under 1 Year Months Days If Under 24 Hrs. Hours Min.
8. Date of Birth Sept. 20, 1922		9. Birthplace (State or Foreign Country) MA		
10a. State MD		10b. County Montgomery		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
10c. City, Town or Location Silver Spring		10f. Zip Code 20906		10g. Citizen of What Country? USA
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Procurement Officer		16b. Kind of Business Industry US Government
17. Father's Name (First, Middle, Last) Frederick William Plummer		18. Mother's Name (First, Middle, Maiden Surname) Beryl Kennedy		
19a. Informant's Name/Relationship (Type, Print) Frances Hunteman/Personal Rep.		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3210 Norbeck Road, #210, Silver Spring, MD 20906		
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		Date 1 20c. Location - City or Town, State March 9, 2012 Alexandria, VA
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Due to (or as a consequence of): Dementia		Approximate Interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23c. Due to (or as a consequence of):		
		23d. Due to (or as a consequence of):		
		23e. Due to (or as a consequence of):		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Infection in Right Hip		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Describe how injury occurred
				28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number D20148		29d. Date signed (Month, Day, Year) Feb. 28, 2012
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Steven Dolinsky, MD 911 Russell Avenue, Gaithersburg, MD 20879		31. Date filed (Month, Day, Year) FEB 29 2012		32. Registrar's Signature 

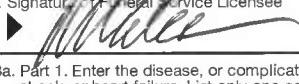
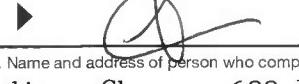
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07992

1 - For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Alice Ward Given					2. Date of Death Month February Day 25 Year 2012	3. Time of Death 6:30 A M		
	4a. Facility Name (if not institution, give street and number) Heritage Harbour Health & Rehab. Center			4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arundel			
Funeral Director	5. Social Security Number 579-28-4835	6. Sex M	7. Age (in yrs. last birthday) 86 Yrs.	If Under 1 Year Months 09	If Under 24 Hrs. Days 15	8. Date of Birth (Month, Day, Year) 09/15/1925	9. Birthplace (State or Foreign Country) Pennsylvania		
	Usual Residence of Decedent Maryland Anne Arundel			10c. City, Town or Location Annapolis		10d. Inside City Limits Yes			
To Be Completed by Funeral Director	10a. State Maryland			10b. County Anne Arundel		10e. Street and Number 505 Harbor Drive		10f. Zip Code 21403	10g. Citizen of What Country? United States
	11. Marital Status Never Married			12. Was Decedent Ever in U.S. Armed Forces? Yes		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) No			14. Race - American Indian, Black, White, etc. White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)		16b. Kind of Business/Industry Accountant				
17. Father's Name (First, Middle, Last) Harry Leroy Fitzpatrick			18. Mother's Name (First, Middle, Maiden Surname) Rose Ward						
19a. Informant's Name/Relationship (Type, Print) John Given /Son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 505 Harbor Drive, Annapolis, Maryland 21403						
20a. Method of Disposition Burial			20b. Place of Disposition (Name of cemetery, crematory or other place) Woodbrook Cemetery		Date 3/2/2012	20c. Location - City or Town, State Woburn, MA			
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, MD 21037						
Physician/ Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Caecum Amytoma</i>							Approximate Interval Between Onset and Death	
	<p>a. Due to (or as a consequence of): <i>Caecum Amytoma</i></p> <p>b. Due to (or as a consequence of): <i></i></p> <p>c. Due to (or as a consequence of): <i></i></p> <p>d. Due to (or as a consequence of): <i></i></p>								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? Yes		23c. If yes, outcome of pregnancy Live Birth Fetal death Ectopic pregnancy Pregnant at time of death Other (specify) Unknown					23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Failure to home</i>							23e. Did tobacco use contribute to the cause of death? Yes No Probably Unknown		
							24a. Was an autopsy performed? Yes No		
							24b. Were autopsy findings available prior to completion of cause of death? Yes No		
25. Was case referred to medical examiner? Yes		26. Place of Death (Check only one) Hospital: Inpatient ER/Outpatient DOA Other: Nursing Home Residence Other (Specify)							
27. Manner of Death Natural Pending Investigation Accident Could not be determined Suicide Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? Yes No	28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) Certifying Physician : To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner : On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner : To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number D57028		29d. Date signed (Month, Day, Year) 02/27/2012			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Aditya Chopra, 600 Ridgely Avenue, Suite 231, Annapolis, Maryland 21401									
31. Date filed (Month, Day, Year) FEB 28 2012		32. Registrar's Signature 							

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**State
Registrar**

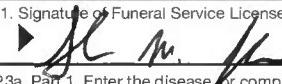
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07993

1 - For
State
RegistrarPhysician/
Medical
Examiner

		1. Decedent's Name (First, Middle, Last) Diane Elizabeth Gittings				2. Date of Death Month MARCH Day 08 , Year 2012	3. Time of Death 10:40 AM		
		4a. Facility Name (if not institution, give street and number) Meritus Medical Center				4b. City, Town, or Location of Death Hagerstown	4c. County of Death Washington		
Funeral Director		5. Social Security Number 215-72-8324	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 54 Yrs.	If Under 1 Year Months 	If Under 24 Hrs. Days 	8. Date of Birth (Month, Day, Year) April 4, 1957	9. Birthplace (State or Foreign Country) Washington, DC	
To Be Completed by Funeral Director		10a. State Maryland	10b. County Washington	10c. City, Town or Location Hagerstown				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
		10e. Street and Number 13012 Hoosier Court				10f. Zip Code 21740	10g. Citizen of What Country? United States		
		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+			16b. Kind of Business/Industry Management Consultant Consulting		
		17. Father's Name (First, Middle, Last) John Lee Petty				18. Mother's Name (First, Middle, Maiden Surname) Jean Elizabeth Beall			
		19a. Informant's Name/Relationship (Type, Print) Kent E. Gittings / Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13012 Hoosier Court, Hagerstown, Maryland 21740			
Physician/ Medical Examiner		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Parklawn Mem. Park			Date March 12, 2012	20c. Location - City or Town, State Rockville, Maryland	
Medical Certificate: To Be Completed by Physician/Medical Examiner		21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Keeney and Basford PA Funeral Home MO1473 106 East Church St., Frederick, Maryland 21701					
		23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
		<p>a. Due to (or as a consequence of): ENDOCARDITIS</p> <p>b. Due to (or as a consequence of): ACUTE HEMORRHAGIC BRAIN BLEED</p> <p>c. Due to (or as a consequence of): ANEMIA</p> <p>d. Due to (or as a consequence of): MYOCARDIAL INFARCTION</p>							
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				23f. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year) 	28b. Time of injury M	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred 		
		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 				28f. Location (Street and Number or Rural Route Number, City or Town, State) 	
		29b. Signature and title of certifier Mohammed A212		29c. License number D66892				29d. Date signed (Month, Day, Year) 3/8/12	
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mohammed A212, MD 11116 Medical Campus Rd, Hagerstown, MD							
State Registrar		31. Date filed (Month, Day, Year) MAR 14 2012		32. Registrar's Signature S. Parker					

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

15 pm

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07994

1 - For
State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Telita Johnson Holloway							2. Date of Death Month 02 Day 23 Year 2012	3. Time of Death 01:25 PM	
	4a. Facility Name (if not institution, give street and number) Suburban Hospital				4b. City, Town, or Location of Death Bethesda			4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 577-62-2673		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 64 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 06/03/1947	9. Birthplace (State or Foreign Country) Washington, DC		
	Usual Residence of Decedent		10a. State DC				10b. County		10c. City, Town or Location Washington, DC	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
To Be Completed by Funeral Director	10e. Street and Number 2855 Bladensburg Rd. #528				10f. Zip Code 20017			10g. Citizen of What Country? United States		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Administration			16b. Kind of Business/Industry Government			
	17. Father's Name (First, Middle, Last) Landon Kyles				18. Mother's Name (First, Middle, Maiden Surname) Eleanor Rae Johnson					
	19a. Informant's Name/Relationship (Type, Print) Sherri Candelario (daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 630 Loudon Ave Roanoke, VA 24016					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) ► Wanda C Bacon			20b. Place of Disposition (Name of cemetery, crematory or other place) Stonewall Mem. Gdns		Date 03/03/12	20c. Location - City or Town, State Manassas, VA			
	21. Signature of Funeral Service Licensee ► Wanda C Bacon			22. Name and Address of Facility W.H. Bacon Funeral Home 3447 14th St NW Wash., DC 20010						
Physician/ Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pneumonia							Approximate Interval Between Onset and Death		
	a. Due to (or as a consequence of): Pneumonia									
	b. Due to (or as a consequence of):									
	c. Due to (or as a consequence of):									
	d. Due to (or as a consequence of):									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year		
Medical Certificate: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA			Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred				
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	29b. Signature and title of certifier ► Troung Bao		29c. License number D0057124			29d. Date signed (Month, Day, Year) 02/24/2012				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Troung Bao 10110 Molecular Dr. Ste 208 Rockville, MD 20850									
State Registrar	31. Date filed (Month, Day, Year) FEB 29 2012		32. Registrar's Signature Leanne P. Garcia							

Baltimore, Maryland 21215-0036
 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial permit.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07995

1- For
State
RegistrarPhysician/
Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial slip.

Medical Certificate: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Alice A. Hickey		2. Date of Death Month February Day 25 , Year 2012	3. Time of Death 11:05A.M.
4a. Facility Name (if not institution, give street and number) Renaissance Gardens at Riderwood Village		4b. City, Town, or Location of Death Silver Spring	
4c. County of Death Prince George's			
5. Social Security Number 486-30-7962	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days Hours Min.
		8. Date of Birth (Month, Day, Year) Dec. 18, 1928	
		9. Birthplace (State or Foreign Country) Missouri	
Usual Residence of Decedent			
10a. State Maryland	10b. County Prince George's	10c. City, Town or Location Beltsville	
10e. Street and Number 13203 Taney Drive		10f. Zip Code 20705	10g. Citizen of What Country? United States
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker	16b. Kind of Business Industry own home
17. Father's Name (First, Middle, Last) Hubert Herigon		18. Mother's Name (First, Middle, Maiden Surname) Hilda Levin	
19a. Informant's Name/Relationship (Type, Print) Thomas Hickey -son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13203 Taney Drive Beltsville, Maryland 20705	
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cem.	Date 2/28/2012
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705	
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.			
Immediate Cause (Final disease or condition resulting in death) Arteriosclerotic Cerebral Vascular Disease			
Approximate Interval Between Onset and Death 5 years			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			
<p>a. Due to (or as a consequence of): Hyperlipidemia</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____	
		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Atrial Fibrillation; Advanced Dementia			
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
Hospital:		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M
		28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input checked="" type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number R158667	
29b. Signature and title of certifier 		29d. Date signed (Month, Day, Year) 2/27/2012	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eileen Gemmell, CRNP 3160 Gracefield Road Silver Spring, Maryland 20904			
31. Date filed (Month, Day, Year) FEB 29 2012		32. Registrar's Signature 	

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07995

1 - For State Registrar

**Physician/
Medical
Examiner**

**Funeral
Director**

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

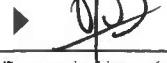
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**Physician/
Medical
Examiner**

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit slip.

		1. Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death					
		Ruth Elaine Hurley				Month February Day 26 Year 2012		12:19 A M					
		4a. Facility Name (if not institution, give street and number)				4b. City, Town, or Location of Death		4c. County of Death					
		Northampton Manor				Frederick		Frederick					
		5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year		If Under 24 Hrs.		8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)			
		215-40-0021	1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	69 Yrs.	Months	Days	Hours	Min.	May 29, 1942	Maryland			
		Usual Residence of Decedent								10d. Inside City Limits			
		10a. State	10b. County	10c. City, Town or Location				10d. Inside City Limits					
		Maryland	Frederick	Frederick				1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
		10e. Street and Number				10f. Zip Code		10g. Citizen of What Country?					
		8608 E. Patrick Street				21701		United States					
		11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			14. Race - American Indian, Black, White, etc. Specify: White				
		1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:							
		15. Decedent's Education (Specify only highest grade completed)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business/Industry				
		Elementary/Secondary (0-12)		College (1-4 or 5+)		Supervisor			Drug Store				
		17. Father's Name (First, Middle, Last)				18. Mother's Name (First, Middle, Maiden Surname)							
		Harold Brown				Margaret Scheller							
		19a. Informant's Name/Relationship (Type, Print)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)							
		Alfred E. Hurley / Husband				8608 E. Patrick Street Frederick, Maryland 21701							
		20a. Method of Disposition				20b. Place of Disposition (Name of cemetery, crematory or other place)		Date		20c. Location - City or Town, State			
		1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State				Stauffer Crematory		February 28, 2012		Frederick, Maryland			
		4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)											
		21. Signature of Funeral Service Licensee				22. Name and Address of Facility				Stauffer Funeral Homes, P.A.			
						8 E. Ridgeville Blvd. Mt. Airy, Maryland 21771							
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death			
		Immediate Cause (Final disease or condition resulting in death)								months			
		COPD CANCER											
		a. Due to (or as a consequence of):											
		b. Due to (or as a consequence of):											
		c. Due to (or as a consequence of):											
		d. Due to (or as a consequence of):											
		IF FEMALE:		23c. If yes, outcome of pregnancy						23d. Date of delivery			
		23b. Was decedent pregnant in the past 12 months?		1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown						Month Day Year			
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death?			
										1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
										24a. Was an autopsy performed?			
										24b. Were autopsy findings available prior to completion of cause of death?			
										1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
		25. Was case referred to medical examiner?		26. Place of Death (Check only one)									
		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
		27. Manner of Death		28a. Date of injury (Month, Day, Year)		28b. Time of injury		28c. Injury at work?		28d. Describe how injury occurred			
		1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		M		M		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
		3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)			
		29a. Certifier		29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
												29c. License number	
		29b. Signature and title of certifier		06862223								29d. Date signed (Month, Day, Year)	
												2/27/12	
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		31. Date filed (Month, Day, Year)								32. Registrar's Signature	
		Mayleen K. Hurley, 19677 Drive, Frederick, MD 21781		FEB 28 2012									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07991

1 - For
State
RegistrarPhysician/
Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/
Medical
Examiner

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12
State
Registrar

		1. Decedent's Name (First, Middle, Last) Debra Ann Hall						2. Date of Death Month 2 Day 17 Year 12		3. Time of Death 352 PM			
		4a. Facility Name (if not institution, give street and number) University of Maryland			4b. City, Town, or Location of Death Baltimore			4c. County of Death					
		5. Social Security Number 459-13-3799		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 51 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) April 16, 1960		9. Birthplace (State or Foreign Country) Texas			
		10a. State Maryland		10b. County Frederick		10c. City, Town or Location Walkersville					10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
		10e. Street and Number 8 E. Frederick St.				10f. Zip Code 21793			10g. Citizen of What Country? United States				
		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Business Administration			16b. Kind of Business/Industry Business				
		17. Father's Name (First, Middle, Last) James Frederick Scroggins				18. Mother's Name (First, Middle, Maiden Surname) Iva Nell Ballou							
		19a. Informant's Name/Relationship (Type, Print) Bill A. Hall, Jr./ Spouse				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 E. Frederick, St./ Walkersville, MD 21793							
		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Stauffer Crematory				20b. Place of Disposition (Name of cemetery, crematory or other place)			Date 2-28-2012	20c. Location - City or Town, State Frederick, Maryland			
		21. Signature of Funeral Service Licensee Sharon Camille Colene				22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike/ Frederick, MD 21702							
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) hyperkalemia renal failure Due to (or as a consequence of): months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last { Due to (or as a consequence of): d.										Approximate Interval Between Onset and Death	
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year				
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Severe anemia ventricular arrhythmia										23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			23f. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide				28a. Date of injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)							28f. Location (Street and Number or Rural Route Number, City or Town, State)				
		29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
		29b. Signature and title of certifier Kathleen Stephanos				29c. License number 1235438714			29d. Date signed (Month, Day, Year) 2/17/12				
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kathleen Stephanos 22 S. Greene St. Baltimore MD 21201											
		31. Date filed (Month, Day, Year) FEB 28 2012		32. Registrar's Signature Laura S. Park									

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 07998

1 - For
State
Registrar

Physician/
Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

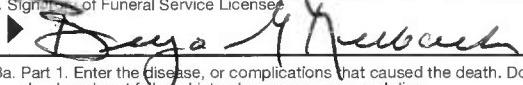
Permit: Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician/
Medical
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year				3. Time of Death			
Raymond Edward Hutzler			February 22, 2012				11:13 A.M.			
4a. Facility Name (if not institution, give street and number)			4b. City, Town, or Location of Death				4c. County of Death			
5870 Cari Road			Huntingtown				Calvert			
5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year		If Under 24 Hrs.		8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)	
220-40-8263		1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	69 Yrs.	Months	Days	Hours	Min.	12/23/1942	Pennsylvania	
Usual Residence of Decedent										
10a. State	10b. County		10c. City, Town or Location						10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
MD	Calvert		Huntingtown							
10e. Street and Number			10f. Zip Code				10g. Citizen of What Country?			
5870 Cari Road			20639				U.S.A.			
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white		
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced										
15. Decedent's Education (Specify only highest grade completed)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business/Industry				
Elementary/Secondary (0-12) 12			College (1-4 or 5+) Chief of Road Operations			Anne Arundel County				
17. Father's Name (First, Middle, Last)				18. Mother's Name (First, Middle, Maiden Surname)						
Raymond Edward Hutzler				Doris Mae Zimmerman						
19a. Informant's Name/Relationship (Type, Print)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)							
Mary Frances Hutzler, wife			5870 Cari Road, Huntingtown, MD 20639							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place)			Date		20c. Location - City or Town, State		
			So. Memorial Gardens			02/25/2012		Dunkirk, MD		
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 20736							
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)			23b. Due to (or as a consequence of): <i>Bladder Cancer</i>						Approximate Interval Between Onset and Death	
{										
b. Due to (or as a consequence of):										
c. Due to (or as a consequence of):										
d. Due to (or as a consequence of):										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown						23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined			28a. Date of injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier 		29c. License number 06502						29d. Date signed (Month, Day, Year) 2/24/12		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Jason Ticey 2023 Medical Plaza Suite 210 Annapolis MD 21401</i>										
31. Date filed (Month, Day, Year)			32. Registrar's Signature							
FEB 28 2012										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 07999

1- For
State
Registrar

Physician/
Medical
Examiner

Funeral
Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) EVELYN FLORENCE HALL			2. Date of Death Month February Day 26 , Year 2012				3. Time of Death 2:35 AM	
4a. Facility Name (if not institution, give street and number) National Lutheran Home			4b. City, Town, or Location of Death Rockville				4c. County of Death Montgomery	
5. Social Security Number 505-22-8351		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) 88 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	Min.	8. Date of Birth (Month, Day, Year) April 21, 1923	9. Birthplace (State or Foreign Country) Nebraska
Usual Residence of Decedent 10a. State Maryland 10b. County Montgomery 10c. City, Town or Location Rockville 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
10e. Street and Number 9701 Veirs Drive Rm 1 VA-120			10f. Zip Code 20850				10g. Citizen of What Country? United States	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business Industry Own Home		
17. Father's Name (First, Middle, Last) Henry Nobbman					18. Mother's Name (First, Middle, Maiden Surname) Ida Kickbush			
19a. Informant's Name/Relationship (Type, Print) Carol Currey (Daughter)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15306-I Diamond Cove Terrace Rockville, MD 20850					
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) Entombment			20b. Place of Disposition (Name of cemetery, crematory or other place) Florida Mem. Gardens			Date March 2, 2012	20c. Location - City or Town, State Rockledge, Florida	
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr. Gaithersburg, MD 20877					

Physician/
Medical
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Underlying Cause (Disease or injury that initiated events resulting in death) Last		23c. Approximate Interval Between Onset and Death	
<p>a. Due to (or as a consequence of): DEMENTIA</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		26. Place of Death (Check only one)	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number D0064624			
29b. Signature and title of certifier 		29d. Date signed (Month, Day, Year) 2-26-2012			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SANDEEP SHRESTHA 9701 VEIRS DR. ROCKVILLE, MD 20850					
31. Date filed (Month, Day, Year) FEB 28 2012		32. Registrar's Signature 			

State
Registrar

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial transit slip.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

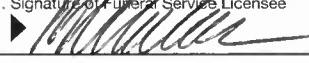
Certificate of Death

Reg. No. 2012 08000

1- For
State
RegistrarPhysician/
Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Harry T. Houchens, Jr.				2. Date of Death Month February Day 24 , Year 2012	3. Time of Death 10:40 PM				
4a. Facility Name (if not institution, give street and number) Anne Arundel Medical Center				4b. City, Town, or Location of Death Annapolis					
4c. County of Death Anne Arundel									
5. Social Security Number 217-32-4497	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 75 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) July 3, 1936	9. Birthplace (State or Foreign Country) Maryland			
Usual Residence of Decedent 10a. State Maryland 10b. County Anne Arundel 10c. City, Town or Location Annapolis						10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number 2924 South Haven Drive				10f. Zip Code 21401		10g. Citizen of What Country? USA			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) 9th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Home Builder		16b. Kind of Business Industry Construction					
17. Father's Name (First, Middle, Last) Harry T. Houchens, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Dorothy Louise Jenkins					
19a. Informant's Name/Relationship (Type, Print) Dorothy Houchens/ Wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2924 South Haven Drive, Annapolis, MD 21401						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Lakemont Cemetery		Date 2/29/12	20c. Location - City or Town, State Davidsonville, MD			
21. Signature of Funeral Services Licensee 			22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037						
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death		
<p>a. <i>Aneumonia</i> Due to (or as a consequence of):</p> <p>b. <i>Tung cancer</i> Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year) M		28b. Time of injury M		28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number DR8510				29d. Date signed (Month, Day, Year) 02/24/12			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen Olexo AACMC									
31. Date filed (Month, Day, Year) FEB 28 2012		32. Registrar's Signature 							